

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13371

13374

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, Towson, Md. 21204				d. STREET ADDRESS Ebenezer Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JOHN Middle R. Last AFFELD				4. DATE OF DEATH Month October Day 29 Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 10-31-98		
9. AGE (In years lost birthday) yrs. 68		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Ownbusiness		11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John R. Affeld				14. MOTHER'S MAIDEN NAME Mary Smith				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 215-01-5759		17. INFORMANT Mrs Marie E. Affeld Address Ebenezer Road White Marsh			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction - white thrombus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary thrombosis DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-27 , 19 67 , to 10-29 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-29 , 19 67 , and that death occurred at 2:28 PM , from causes and on the date stated above.								
22a. SIGNATURE William				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-29-67		
22c. PHYSICIAN'S NAME (Type) Ines Cilliani M.D.				22d. ADDRESS 7620 York Road, Towson, Maryland 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-1-1967		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Joppa Md.		
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road				25a. REC'D BY REGISTRAR 36		25b. REGISTRAR'S SIGNATURE Charles Judge		
				DATE NOV 1 1967				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13372					13375				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Baltimore					a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					b. COUNTY Anne Arundel				
c. LENGTH OF STAY IN 1b 6 months					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Forest Haven Nursing Home					d. STREET ADDRESS Rte. 2, Box 114				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last Edith Aiken					Month Day Year Oct. 31, 1967				
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 24, 1875		9. AGE (In years last birthday) 92 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker		10b. KIND OF BUSINESS OR INDUSTRY Ret.		11. BIRTHPLACE (County & State, or foreign country) Baltimore,		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Matthew Kelly					14. MOTHER'S MAIDEN NAME Virginia Jerome				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. 214-20-0334				
17. INFORMANT Mary H. Seaman					Address Same as 2.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 MYOCARDIAL INFARCTION - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 10/21/67 MYOCARDIAL INFARCTION - DUE TO (c) DISSEMINATED PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 7/1, 1962, to 10/31, 1967, that (I) (we) last saw the deceased alive on 10/31, 1967, and that death occurred at 6:20 PM, from the causes and on the date stated above.									
22a. SIGNATURE John Shaw, M.D.					22b. DATE SIGNED 11/1/67				
22c. PHYSICIAN'S NAME (Type) John Shaw, M.D.					22d. ADDRESS 5800 Edmondson Ave. Baltimore, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 11-3-67				
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery					23d. LOCATION (City, town or county) (State) Baltimore Md.				
24. FUNERAL DIRECTOR Kirkley Funeral Home, 421 Crain Hwy., S.E.,					25a. REC'D BY REGISTRAR Glen Burkle, Md. 21061 25b. REGISTRAR'S SIGNATURE J. Charles Judge				

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RECORDS OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13373 CERTIFICATE OF DEATH 13376

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Garrison c. LENGTH OF STAY IN 1b 3 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Foxleigh Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 7028 Yataruba Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie W. Albert		4. DATE OF DEATH Oct. 23, 1967	
5. SEX Female	6. COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1888
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR: Months 10 Days 19 IF UNDER 24 HRS: Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Conrad Roemer		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-10-5729 D	
17. INFORMANT Mrs. Donald LeBlanc		Address 7028 Yataruba Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Brain Syndrome 4201 DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease with recent myocardial necrosis, prob. infarct DUE TO (c) myocardial necrosis, prob. infarct			INTERVAL BETWEEN ONSET AND DEATH 3 months One month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1965 to 10-24 , 19 67 , that (I) (we) last saw the deceased alive on 10-24 , 19 67 , and that death occurred at 3:00 M, from the causes and on the date stated above.			
22a. SIGNATURE Rafael A. Perez-Mera		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Rafael A. Perez-Mera, M.D.		22d. ADDRESS 7306 Liberty Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 26, 1967	
23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		23d. LOCATION (City, town or county) (State) Baltimore	
24. FUNERAL DIRECTOR Charles Lemmon		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS 4611 Park Heights Av. Balto.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE OCT 30 1967			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13374

13377

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxliegh</u>		d. STREET ADDRESS <u>11127 Reisterstown Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>G.</u> Last <u>Allard</u>		4. DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1894</u>
9. AGE (In years last birthday) yrs. <u>73</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William South Ward</u> <u>Abel Clare Allard</u>		14. MOTHER'S MAIDEN NAME <u>Alwilda Garnett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-09760</u>	
17. INFORMANT <u>Mr. Aubrey C. Allard</u>		Address <u>Baltimore 20, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>Carcinoma of colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>unborn</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>9-19</u> , 19 <u>67</u> , to <u>10-16</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>10-15</u> , 19 <u>67</u> , and that death occurred at <u>6:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>David I. Miller</u>		22b. DATE SIGNED <u>10-16-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>David I. Miller</u>		22d. ADDRESS <u>Union Rd., Owings Mills, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md.</u>
24. FUNERAL DIRECTOR <u>J. F. Eline & Sons</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 19 1967</u>	
ADDRESS <u>Reisterstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ad</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barbersville</u> d. STREET ADDRESS <u>0272</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Belinda</u> Middle <u>Irene</u> Last <u>Allen</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>4</u> Year <u>1967</u>								
5. SEX <u>F</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/12/57</u>		9. AGE (In years last birthday) <u>10</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>elem. school</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Melvin K. Allen</u>				14. MOTHER'S MAIDEN NAME <u>Heddie Peterson</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Father Chart</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory & cardiac</u> <u>1939</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arrest due to Intracranial</u> DUE TO (c) <u>medulloblastoma & metastases (?)</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9-23</u> , 19 <u>67</u> , to <u>Oct 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 4</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>J. de Castro</u>						22b. DATE SIGNED <u>10/4/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>MA. JOSEFINA A. DE CASTRO</u>						22d. ADDRESS <u>Greater Baltimore Medical Center</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>10/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Leonard</u>			23d. LOCATION (City, town or county) (State) <u>Calverton, Md.</u>			
24. FUNERAL DIRECTOR <u>Samuel, Md.</u>						25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			
						DATE <u>OCT 10 1967</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13376

CERTIFICATE OF DEATH

13379

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>		c. LENGTH OF STAY IN 1b <u>52 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>White Hall Rd.</u>		d. STREET ADDRESS <u>White Hall Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Lydia Adele Almony</u>		4. DATE OF DEATH <u>OCT. 5</u> 19 <u>67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7/1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>White Hall, Md.</u>
13. FATHER'S NAME <u>John Thomas Almony</u>		14. MOTHER'S MAIDEN NAME <u>Annie E. Shane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-14-7900</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221</u> DUE TO (b) <u>C. S. C. V. Disease</u> DUE TO (c) <u>lost.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , to <u>10/5/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/4</u> 19 <u>67</u> , and that death occurred at <u>1 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>G. M. France</u>		22b. DATE SIGNED <u>10/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		22d. ADDRESS <u>PHAXTON, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Oct. 7/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Verpon Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>White Hall, Md.</u>
24. FUNERAL DIRECTOR <u>Isaac Portenstien, New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1337

CERTIFICATE OF DEATH

1337



U.S. DEPARTMENT OF COMMERCE
BUREAU OF CENSUS
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers; Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

13377

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13380

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Baltimore #21213		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 4005 Ardley Avenue		
3. NAME OF DECEASED (Type or print) MICHAEL First JOSEPH Middle BOY Last AMRHEIN		4. DATE OF DEATH Month October Day 15 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH September 12 1967	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 3 Hours 3 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John B. Amrhein		14. MOTHER'S MAIDEN NAME Anna M. Kuchta		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		
17. INFORMANT Father, above		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7593 IMMEDIATE CAUSE (a) Multiple malformations DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		20g. (County)		20h. (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 12 1967 , to October 15 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 15 1967 , and that death occurred at 4:45 AM , from causes on and on the date stated above.				
22a. SIGNATURE Reynaldo Orjuela - Gomez, M.D.		22b. DATE SIGNED 10-15-67		22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS 7620 York Road, Towson, Md. 21204		22e. REGISTRAR'S SIGNATURE Oct 17 1967		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/16/67		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.
23d. LOCATION (City or Town) Baltimore, Md.		23e. REGISTRAR'S SIGNATURE Oct 17 1967		
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		24a. REC'D BY REGISTRAR Oct 17 1967		
24b. ADDRESS 3331 Brehms Lane		24c. REGISTRAR'S SIGNATURE Oct 17 1967		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13378					13381				
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY MD.				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTO.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center					d. STREET ADDRESS 118 W. 25th ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Charles			First Walter		Middle Anderson		Last Anderson		4. DATE OF DEATH Month 10 Day 31 Year 19 67
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7/30/08	9. AGE (in years last birthday) 59 yrs.	10. IF FUNER 1 YEAR Months 10 Days 31 Hours 19 Min. 67	11. BIRTHPLACE (County & State, or foreign country) N.J.	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME ?	14. MOTHER'S MAIDEN NAME ?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR			10b. KIND OF BUSINESS OR INDUSTRY NEWS PAPERMAN		11. BIRTHPLACE (County & State, or foreign country) N.J.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 053-05-7582		17. INFORMANT Patient's Chart		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolization DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of lung DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 10/30 , 19 67 , to 10/31 , 19 67 , that (I) (we) last saw the deceased alive on 10/31 , 19 67 , and that death occurred at 12:55 M. , from the causes and on the date stated above.
22a. SIGNATURE John E. Adams			M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/31/67
22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D.			22d. ADDRESS 6701 N. Charles Street						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 11/3/67		23c. NAME OF CEMETERY OR CREMATORY LOUPON PARK		23d. LOCATION (City, town or county) (State) BALTO MD.		24. FUNERAL DIRECTOR Paul E. Charney
25a. REC'D BY REGISTRAR NOV 6 1967			25b. REGISTRAR'S SIGNATURE J. Charles Judge						

1880

1880

John S. Adams

NOV 6 1880

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13379

13382

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1271 Maple Ave.				d. STREET ADDRESS 1271 Maple Ave. 21227			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Addie J. Augsburger				4. DATE OF DEATH Month October Day 23 Year 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 3, 1894		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Foreman				14. MOTHER'S MAIDEN NAME Lottie MacAbee					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 		17. INFORMANT Address 21227 Mrs. Isabel Neighoff, 1271 Maple Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitastatic Carcinoma Lungs 180X DUE TO (b) Carcinoma of Right Kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 4 mo. undet.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 23, 1967 , to Oct. 23, 1967 that (I) (we) last saw the deceased alive on Oct 22, 1967 , and that death occurred at 4:45 PM , from causes and on the date stated above.									
22a. SIGNATURE A. Bradley Daugharthy M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-24-67	
22c. PHYSICIAN'S NAME (Type) A. Bradley Daugharthy						22d. ADDRESS 1264 Francis Ave.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/26/67		23c. NAME OF CEMETERY OR CREMATORY Stevensville Cemetery		23d. LOCATION (City or Town) (County) (State) Stevensville Kent Md.			
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229						25a. REC'D BY REGISTRAR ACT 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13285

UNITED STATES DEPARTMENT OF AGRICULTURE

13285

TO THE SECRETARY OF AGRICULTURE
WASHINGTON, D. C.
FROM THE DIRECTOR OF THE BUREAU OF PLANT INDUSTRY
SUBJECT: [Illegible]

[Illegible text block containing several paragraphs of a memorandum or report.]

[Illegible text block containing a signature and possibly a date or reference number.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

<div>13380</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>13383</div>										
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN TB 13 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) QUANTICO					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL					d. STREET ADDRESS RFD 1, Box 22			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First GEORGE Middle W. Last AUSTIN					4. DATE OF DEATH Month OCTOBER Day 19 Year 19 67					
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7/16/18		9. AGE (In years lost birthday) yrs. 49		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER			10b. KIND OF BUSINESS OR INDUSTRY TRUCKING COMPANY		11. BIRTHPLACE (County & State, or foreign country) QUANTICO, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM AUSTIN					14. MOTHER'S MAIDEN NAME SARAH CHURCH					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II			16. SOCIAL SECURITY NO. 219 07 62 33		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF RECTUM WITH WIDESPREAD METASTASIS 154 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH UNKNOWN		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from 10/6/67 , 19__, to 10/19/67 , 19__, that (X) (we) last saw the deceased alive on 10/19/67 , 19__, and that death occurred at 12:55AM from causes and on the date stated above.										
22a. SIGNATURE <i>George C. McElpatrick</i> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/19/67			
22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D.					22d. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/23/67		23c. NAME OF CEMETERY OR CREMATORY FAMILY CEMETERY			23d. LOCATION (City or Town) (County) (State) QUANTICO MARYLAND			
24. FUNERAL DIRECTOR <i>Clinton S. Stewart</i>					ADDRESS CLINTON S. STEWART		25a. REC'D BY REGISTRAR OCT 25 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	
					ADDRESS SALISBURY, MARYLAND					

11/1/52

STATEMENT OF DEATH

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MARYLAND

WITNESS

13 DAYS

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12381

CERTIFICATE OF DEATH

13384

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1525 POPALNO STREET	
3. NAME OF DECEASED (Type or print) First HARRY Middle STEPHEN Last BAKUN		4. DATE OF DEATH Month OCTOBER Day 6 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/95
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BURNER		10b. KIND OF BUSINESS OR INDUSTRY U.S. COAST GUARD	9. AGE (In years last birthday) yrs. 72
11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STEPHEN BAKUN		14. MOTHER'S MAIDEN NAME USTENA DULEVAR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 213 05 57 37	
17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS 150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY EMPHYSEMA (c) MALNUTRITION DUE TO CARCINOMA OF ESOPHAGUS		INTERVAL BETWEEN ONSET AND DEATH MONTHS YEARS MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CYSTITIS, CHRONIC. DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from SEPTEMBER 30, 1967 to OCTOBER 6, 1967 , that he (we) last saw the deceased alive on OCTOBER 6, 1967 , and that death occurred at 2:10 A.M. from causes and on the date stated above.			
22a. SIGNATURE George Dudas		22b. DATE SIGNED 10/6/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF OCT. 9, 1967	23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEMETERY	23d. LOCATION (City or Town) (County) (State) BALTO. MARYLAND
24. FUNERAL DIRECTOR HAHN FUNERAL HOME		25a. REC'D BY REGISTRAR DATE OCT 9 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13382

CERTIFICATE OF DEATH

13385

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Lansdowne			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 219 Elizabeth Ave.				d. STREET ADDRESS Kingsville, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pearl Middle Eileen Last Bauer				4. DATE OF DEATH Month October Day 25 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/4/18		9. AGE (In years last birthday) yrs. 49	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME - - - - Schultz				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Charles J. Bauer, Mt. Calvert Springs Motel, Rt. 1, Kingsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma DUE TO (c) Carcinoma of the Cervix Epidermoid							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/67 , to 10/26/67 , that (I) (we) last saw the deceased alive on 6/67 19 67 , and that death occurred at 4:47 AM , from causes and on the date stated above.							
22a. SIGNATURE Marvin Sager				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/26/67	
22c. PHYSICIAN'S NAME (Type) Marvin Sager				22d. ADDRESS 3904 S. Hanover St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/27/67		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Ritchie Hgwy. Arundel Md.	
24. FUNERAL DIRECTOR ADDRESS Hubbard Funeral Home, 4107 Wilkens Ave. 21229				25a. REC'D BY REGISTRAR DATE OCT 27 1967		25b. REGISTRAR'S SIGNATURE O'Donoghue, Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. Page 2 must be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13383						13386					
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Jennie NMT Beerman						4. DATE OF DEATH Month Day Year 10 9 1967					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 83 yrs.		9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY AT HOME				11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? BAROL				14. MOTHER'S MAIDEN NAME UNKNOWN							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. NO		17. INFORMANT Address MR. BARNET BEERMAN, 3330 VIRGINIA AVE. #21215					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL. 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Congestive Heart Failure DUE TO (c) Arterio Sclerotic Heart Disease										INTERVAL BETWEEN ONSET AND DEATH 2 week 3 mos Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-29 to 10-9 , 1967 that (I) (we) last saw the deceased alive on 10-9 , 1967, and that death occurred at 7:15 P. from the causes and on the date stated above.											
22a. SIGNATURE Rolando A. Madamba M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-9-67			
22c. PHYSICIAN'S NAME (Type) ROLANDO A. MADAMBA						22d. ADDRESS BALTIMORE COUNTY GENERAL HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 10-11-67		23c. NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH AITZ CHAIM		23d. LOCATION (City, town or county) BALTIMORE, MARYLAND		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD						ADDRESS DA		25a. REC'D BY REGISTRAR OCT 16 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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BALTIMORE COUNTY GENERAL HOSPITAL

3530 VIRGINIA AVENUE

FEMALE

AT HOME

RUSSIA

SAFOL

UNKNOWN

3530 VIRGINIA AVE. - 41212

BALTIMORE COUNTY GENERAL HOSPITAL

BALTIMORE, MARYLAND

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BURIAL

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SOI LEVINSON & SONS, INC., 4010 PEPPERIDGE ROAD, BALTIMORE, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13384

CERTIFICATE OF DEATH

13387

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 1yr. 5mo.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stella Maris Hospice		d. STREET ADDRESS 203 S. Dunstons Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emelma Middle M. Last Bell		4. DATE OF DEATH Month Oct. Day 27 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-9-1883
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Christian F. Richter		14. MOTHER'S MAIDEN NAME Mary Beck	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-090740	
17. INFORMANT Records of Stella Maris Hospice		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.C.V.D. DUE TO (c) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 16 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 20 May , 19 66 to Oct. 27 , 19 67 , that (I) (we) last saw the deceased alive on Oct. 27 , 19 67 , and that death occurred at 1:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Robert J. Mahon		22b. DATE SIGNED Oct. 27, 67	
22c. PHYSICIAN'S NAME (Type) R. J. MAHON, MD.		22d. ADDRESS 2 04, E. Joppa Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/30/67.	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR OCT 31 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

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RECEIVED THE DEPT.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13385

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13388

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b Hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Plant Dispensary		d. STREET ADDRESS 1719 Melbourne Rd.	
3. NAME OF DECEASED (Type or print) First John Middle M Last Bent Sr.		4. DATE OF DEATH Month Oct. Day 17- Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-21-35
9. AGE (In years lost birthday) 32 yrs.		10. IF UNDER 1 YEAR Months 32 Days 32 Hours 32 Min.	11. IF UNDER 24 HRS. Months 32 Days 32 Hours 32 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipfitter- Beth Steel Co.		10b. KIND OF BUSINESS OR INDUSTRY Shipbldg.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Bent		14. MOTHER'S MAIDEN NAME Edna Lucas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Army 1952-1955		16. SOCIAL SECURITY NO. 215-30-8843	
17. INFORMANT (Wife) Mrs. Carolyn Bent, 1719 Melbourne Rd.		Address Dundalk, Md. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing injuries to entire Thorax and Pelvis 8304 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH Stat.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck & run over by Straddle truck.	
20c. TIME OF INJURY Month 10-17-67 Hour a.m. 8:05 19 67	20d. INJURY OCCURRED White at work <input checked="" type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Shipyard	20f. (City or town) (County) (State) Sparrows Pt. Balto Co. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. Davis, M.D. 6800 Morningside Rd. Dundalk, Md. 21222		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/20/67	
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR OCT 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 10-17-67	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13386

CERTIFICATE OF DEATH

13389

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN lb <u>2 hr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County Gen Hosp.</u>		d. STREET ADDRESS <u>8902 Middlebrook Ct</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Berman</u> Last <u>Berman</u>		4. DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-03</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HILLEL ABRAMS</u>		14. MOTHER'S MAIDEN NAME <u>ANNA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-18-8266</u>	
17. INFORMANT <u>MR. BENJAMIN BERMAN</u>		Address <u>8902 MIDDLEBROOK CT.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prob. Ac. Myocardial Infarction</u> DUE TO <u>260x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u> </u> (c) <u>Diabetic Acidosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Uremia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , to <u>Oct 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-2</u> 19 <u>67</u> , and that death occurred at <u>4:15</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Daniel Bakal</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10-2-67</u>
22c. PHYSICIAN'S NAME (Type) <u>DANIEL BAKAL</u>		22d. ADDRESS <u>3600 LOCKHEAR DR 21207</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-3-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>
24. FUNERAL DIRECTOR <u>SDL LEVIVSON & BROS. INC. 6010 REISTERSTOWN RD.</u>		25. REC'D BY REGISTRAR <u>OCT 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13387 Item #2c & d Film #G39, 11/6/67 ph

CERTIFICATE OF DEATH

13390

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTO. CO.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u> c. LENGTH OF STAY in 1b <u>SEVEN YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MARYLAND MASONIC HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO. CO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MANCHESTER</u> d. STREET ADDRESS <u>334 E. Lorraine Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MISS MATTIE</u> Middle <u>T.</u> Last <u>BIDDISON</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 3, 1878</u>
9. AGE (In years lost birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ZACHARIAH MASON BIDDISON</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH ALLEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-03-1973A</u>	
17. INFORMANT <u>Masonic Home</u>		Address <u>Same as #1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Brain Syndrome</u> (c) <u>Multiple Ischemic ulcer feet</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 15, 1965</u> , to <u>Oct 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 25, 1967</u> , and that death occurred at <u>1:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>JAMSHID HAMED MD</u>		22b. DATE SIGNED <u>OCT 25, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMSHID HAMED MD</u>		22d. ADDRESS <u>MASONIC HOME</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-27-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR <u>W. C. Cook Burial Town</u>		25a. REC'D BY REGISTRAR <u>21206</u>	
25b. REGISTRAR'S SIGNATURE <u>William C. Cook</u>		DATE <u>OCT 27 1967</u>	

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13388

CERTIFICATE OF DEATH

13391

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville	
3. NAME OF DECEASED (Type or print) First Middle Last Randle L. Biden		4. DATE OF DEATH Month Day Year October 13, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1896
9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Biden		14. MOTHER'S MAIDEN NAME Kate Gardner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW1		16. SOCIAL SECURITY NO. 048-03-8078	
17. INFORMANT Mrs. Helen W. Biden		Address 107 Dublin Dr. 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.1 Aortic Stenosis DUE TO (b) C Myocardial Sclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) W.C.V.D.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1964 to Oct 13 1967, that (I) (we) last saw the deceased alive on Oct 13 1967, and that death occurred at 2 PM, from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) AT Paul Bror 19		22d. ADDRESS 5820 York Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 16, 1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204		25a. REC'D BY REGISTRAR OCT 18 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

13381

GRAND JURY OF DEATH

13382

George Thomas
C. M. M. M. M. M.

Oct 10

Oct 10

W. J. M. M. M.

THE OFFICE OF THE DISTRICT ATTORNEY
OF THE DISTRICT OF COLUMBIA
WASHINGTON, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13389

CERTIFICATE OF DEATH

13392

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH e. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HALETHORPE</u> c. LENGTH OF STAY IN b. <u>8 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4316 SPENCER ST</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HALETHORPE</u> d. STREET ADDRESS <u>4316 SPENCER ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SARAH</u> First <u>BLACKWELL</u> Middle Last 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>COLORED</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-5-1908</u> 9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>10</u> <u>25</u> <u>1967</u> Month Day Year		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAFETERIA WORKER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>ELBERTON CO GA.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JAKE BURTON</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. (If yes give number or dates of service)		14. MOTHER'S MAIDEN NAME <u>LIZZIE OGLEBY</u> 17. INFORMANT <u>OTIS BLACKWELL</u> Address <u>4316 SPENCER ST HALETHORPE MD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>hypertensive cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>disease</u> (c), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6-20-1967</u> to <u>1967</u> , that (I) (we) last saw the deceased alive on <u>6-20-1967</u> , and that death occurred at <u>10:25</u> M , from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>TORROT TEOD Y. M.</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>549 N. Fuller Ave</u>		22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/27/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARABUTUS MORN PR</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>2380 Gilmer St</u>		25a. REC'D BY REGISTRAR <u>Oct 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

13185

STATEMENT OF DEATH

13185

STATEMENT OF DEATH

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FOR STATE
 HEALTH DEPT.

13390

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13393

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD - TAYLOR		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A. P. STORE		e. STREET ADDRESS 6914 Belair Road	
3. NAME OF DECEASED (Type or print) L First Middle Last EARL BLAKISTONE		4. DATE OF DEATH Month Day Year OCT 16 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Heusler Printing Company	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert Blakistone		14. MOTHER'S MAIDEN NAME Emma McCubbins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) Yes		16. SOCIAL SECURITY NO. W I	
17. INFORMANT William C. Blakistone		Address 6912 Belair Road-21206	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 MYOCARDIAL INFARCTION IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William A. Pillsbury M.D.		22. DATE SIGNED 10-16-67	
EXAMINER'S NAME (Type) William A. Pillsbury		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address, street, city, town, or county Baltimore Co.	
23a. BURIAL, CREMATION, REINTERMENT Burial	23b. DATE THEREOF 10-19-67	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland-21206
24. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Road-21206		25a. REC'D BY REGISTRAR OCT 23 1967	
		25b. REGISTRAR'S SIGNATURE O'Connell, Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

SECRET

CONFIDENTIAL

TOP SECRET

[Faint, mostly illegible text covering the main body of the page, possibly containing a list or detailed report.]

[Faint text at the bottom of the page, possibly a footer or classification marking.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville 21093	
c. LENGTH OF STAY IN 1b days		d. STREET ADDRESS 251 Meadowvale Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Seibert D. BOLLINGER		4. DATE OF DEATH Month Day Year October 2, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1896
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager Seagram		10b. KIND OF BUSINESS OR INDUSTRY Distillers	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bollinger		14. MOTHER'S MAIDEN NAME Barbara Peeling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes. WW1		16. SOCIAL SECURITY NO. 216-10-9379	
17. INFORMANT Mrs. Mayme L. Bollinger		Address 251 Medowvalle, Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x Cardio respiratory arrest DUE TO (b) Cerebro vascular hemorrhage DUE TO (c) Generalized arteriosclerosis.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 67	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/1/ , 19 67 , to 10/2/ , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/2/ , 19 67 , and that death occurred at 7:40M , from causes and on the date stated above.			
22a. SIGNATURE <i>Beatriz P. Dizon</i>		22b. DATE SIGNED October 2, 1967	
22c. PHYSICIAN'S NAME (Type) Beatriz P. Dizon, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/5/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Parkville, Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		25a. REC'D BY REGISTRAR OCT 5 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove far back papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13392

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13395

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KANDALIS TOWN</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. Co. Gen. Hosp.</u>		d. STREET ADDRESS <u>2401 EUTAW PLACE</u>	
3. NAME OF DECEASED (Type or print) First <u>JANIE</u> Middle <u>—</u> Last <u>BONN</u>		4. DATE OF DEATH Month <u>10</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>10-22-79</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>88</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Henry Rode</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET McALLISTER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>212-07-55190</u>		17. INFORMANT <u>Hosp. Record</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure</u> DUE TO <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC A.DISEASE</u> (c) <u>ATHEROSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 Mos</u> <u>UNKNOWN</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GANGRENE OF RT FOOT</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-20-1967</u> , to <u>10-24-1967</u> , that (I) (we) last saw the deceased alive on <u>10-24-1967</u> , and that death occurred at <u>6 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Rolando A. Madamba</u>		22b. DATE SIGNED <u>10-24-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROLANDO A. MADAMBA MD</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD</u>
24. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>ACT 27 1967</u>	
ADDRESS <u>4210 BELAIR</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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WASHINGTON, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13392 CERTIFICATE OF DEATH 13396											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middlesex					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center						d. STREET ADDRESS 957 ARNCLIFFE ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wilson Middle C Last Boone			4. DATE OF DEATH Month October Day 20 Year 1967								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-12-10		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 03 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAREHOUSEMAN				10b. KIND OF BUSINESS OR INDUSTRY REA EXPRESS		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John W. Boone						14. MOTHER'S MAIDEN NAME ANNA D. TAYLOR					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II				16. SOCIAL SECURITY NO. 212-01-8130		17. INFORMANT ETTA M. BOONE ARNCLIFFE					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of body of the pancreas 157X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/4 , 19 67 , to 10/20 , 19 67 , that (I) (we) last saw the deceased alive on 10/20 , 19 67 , and that death occurred at 5:25M , from the causes and on the date stated above.											
22a. SIGNATURE John E. Adams						P. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/21/67			
22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D.						22d. ADDRESS 6701 N. Charles Street, Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-24-67		23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEMETERY				23d. LOCATION (City, town or county) (State) Baltimore Maryland			
24. FUNERAL DIRECTOR Philip L. Crach				ADDRESS 1211 Chesapeake		25a. REC'D BY REGISTRAR 11-23-1967		25b. REGISTRAR'S SIGNATURE McDonald, Judge			

John E. Adams

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director of the funeral home should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13394

CERTIFICATE OF DEATH

13397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Md. 9000 Carlisle Ave. Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--- Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21236	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION xxx 9001 Carlisle Ave.		d. STREET ADDRESS 9001 Carlisle Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Myrtle Middle May Last Bowers		4. DATE OF DEATH Month October Day 29 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1895
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) York, Penna
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Howard Norris		14. MOTHER'S MAIDEN NAME Mary Emma Day	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-01-4178D	
17. INFORMANT Louise Bowers-Daughter-in-law		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemoptysis-due to possible peptic ulcer 203 X DUE TO Multiple myeloma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
INTERVAL BETWEEN ONSET AND DEATH 5 hrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Spring, 1966 to October, 1967 , that I last saw the deceased alive on Oct, 10, 1967 , and that death occurred at 12:35 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 10-30-67			
ACTUAL SIGNATURE Barbara A. Solomon M.D.			
PHYSICIAN'S NAME (Type) Barbara A. Solomon, M. D.		9660 Belair Rd. Balto 36- Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/1/67.	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS 21214	
24a. REC'D BY REGISTRAR DATE NOV 1 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

1354

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1354

For use by

PLACE IN CASE

1. NAME OF DECEASED
Mr. JAMES H. HARRIS

2. SEX
Male

3. AGE
65

4. DATE OF DEATH
September 21, 1935

5. TIME OF DEATH
10:30 A.M.

6. PLACE OF DEATH
3001 Carlisle Ave., Baltimore 21

7. OCCUPATION
XXX Pool Captain 198

8. CAUSE OF DEATH
Myocardial Infarction

9. MANNER OF DEATH
Natural

10. SIGNATURE OF PHYSICIAN
J. H. Harris

11. SIGNATURE OF REGISTRAR
J. H. Harris

12. DATE OF BIRTH
September 21, 1935

13. PLACE OF BIRTH
Baltimore, Md.

14. OCCUPATION
Pool Captain

15. SIGNATURE OF DECEASED
J. H. Harris

16. SIGNATURE OF WITNESSES
J. H. Harris

17. SIGNATURE OF PHYSICIAN
J. H. Harris

18. SIGNATURE OF REGISTRAR
J. H. Harris

19. SIGNATURE OF DECEASED
J. H. Harris

20. SIGNATURE OF WITNESSES
J. H. Harris

21. DATE
September 21, 1935

22. SIGNATURE OF REGISTRAR
J. H. Harris

23. SIGNATURE OF PHYSICIAN
J. H. Harris

24. SIGNATURE OF REGISTRAR
J. H. Harris

25. DATE
September 21, 1935

26. SIGNATURE OF REGISTRAR
J. H. Harris

27. SIGNATURE OF REGISTRAR
J. H. Harris

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13395

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13398

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 7 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2634 Liberty Parkway		d. STREET ADDRESS 2634 Liberty Parkway	
3. NAME OF DECEASED (Type or print) First Middle Last Rosa K. Bowers		4. DATE OF DEATH Month Day Year October 4, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1886
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Office Work		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William F. Bowers		14. MOTHER'S MAIDEN NAME Amelia Schleilb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-54-1767	
17. INFORMANT (Brother) Carl Bowers, 2634 Liberty Parkway, Dundalk,		Address Md. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Theodore C. Patterson EXAMINER'S NAME (Type)		M.D. 105 Main St. Dundalk, Md. 21222	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR OCT 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

11332

11332

William

William

William

William

William

William

South Liberty Parkway

South Liberty Parkway

James

James

James

James

White

White

Clark - Office Work

Clark - Office Work

William F. Powers

William F. Powers

213-21-1767

213-21-1767

William F. Powers

X

X

X

105 Main St.

105 Main St.

U.S.

U.S.

William F. Powers

William F. Powers

William F. Powers

William F. Powers

John A. Jones, 105 Main St., Portland, Me.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

<div style="display: flex; justify-content: space-between;"> <div> <p>13396</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> </div> <div> <p>13399</p> </div> </div>									
<p>1. PLACE OF DEATH</p> <p>a. COUNTY Baltimore MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk</p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 50 Township Road</p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE Maryland b. COUNTY Baltimore</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk</p> <p>d. STREET ADDRESS 50 Township Road</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>				
<p>3. NAME OF DECEASED (Type or print) JOHN FRANCIS BRADLEY</p> <p>First Middle Last</p>					<p>4. DATE OF DEATH October 23rd 1967</p> <p>Month Day Year</p>				
<p>5. SEX male</p>		<p>6. COLOR OR RACE white</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH June 5, 1888</p>		<p>9. AGE (In years last birthday) 79 yrs.</p> <p>IF UNDER 1 YEAR IF UNDER 24 HRS.</p> <p>Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker</p>			<p>10b. KIND OF BUSINESS OR INDUSTRY Steel</p>		<p>11. BIRTHPLACE (State or foreign country) Pennsylvania</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>		
<p>13. FATHER'S NAME Edward Bradley</p>					<p>14. MOTHER'S MAIDEN NAME Harriet M. Horrell</p>				
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) WWI</p>			<p>16. SOCIAL SECURITY NO. 213-07-4555</p>		<p>17. INFORMANT Mary M. Bradley, same as #2</p> <p>Address</p>				
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) A-S-C-V-Disease</p> <p>4221</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>DUE TO (b)</p> <p>DUE TO (c)</p>								<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p>Peptic ulcer</p>								<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/></p>			<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>						
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. p.m. 19</p>			<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>		
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>									
<p>ACTUAL SIGNATURE M B Davis</p>			<p>M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>Dundalk, Maryland</p> <p>Address (Street, city, town, or county)</p>				<p>22. DATE SIGNED 10/25/67</p>		
<p>EXAMINER'S NAME (Type) Melvin B. Davis, M.D.</p>									
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>			<p>23b. DATE THEREOF 10/26/67</p>		<p>23c. NAME OF CEMETERY OR CREMATORY Baltimore National</p>		<p>23d. LOCATION (City, town or county) (State) Baltimore, Maryland</p>		
<p>24. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk, Md.</p> <p>Address</p>					<p>25a. REC'D BY REGISTRAR OCT 26 1967</p> <p>25b. REGISTRAR'S SIGNATURE Charles Judge</p>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13397

13400

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 5yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		d. STREET ADDRESS 12301 Branfield Ct. #13	
3. NAME OF DECEASED (Type or print) David Patrick Bradshaw		4. DATE OF DEATH Month 10 Day 11 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-7-60
9. AGE (In years last birthday) 7 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent	11. BIRTHPLACE (County & State, or foreign country) Montgomery, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Reuben Joesph Bradshaw	
14. MOTHER'S MAIDEN NAME Winifred Guthrie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Rosewood Records, Owings Mills, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute hemorrhagic Necrosis, Bilateral Adrenal 0571 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Meningococcal Septecemia DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 days 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 8:45 PM.	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5 Dec , 1966, to 10 - 11 , 1967 that (I) (we) last saw the deceased alive on 11 Oct 1967, and that death occurred at 8:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Richard A. Jones		22b. DATE SIGNED 12 Oct 67	
22c. PHYSICIAN'S NAME (Type) Richard A Jones		22d. ADDRESS Rosewood State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-13-67	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE OCT 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

11-100

UNITED STATES OF AMERICA

1900

IN SENATE, January 11, 1900.

REPORT OF THE

COMMISSIONERS OF THE

LAND OFFICE

FOR THE YEAR 1899

AND

FOR THE YEAR 1900

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FOR THE YEAR 1901

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FOR THE YEAR 1902

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FOR THE YEAR 1903

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FOR THE YEAR 1904

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FOR THE YEAR 1905

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
25M 1/67

<div>13398</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>13401</div>									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			c. LENGTH OF STAY IN 1b 23 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital					d. STREET ADDRESS -			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Larry Middle Miller Last BRADY					4. DATE OF DEATH Month 10 Day 30 Year 1967				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-38		9. AGE (In years last birthday) 29 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Prince Frederick, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Owen Brady					14. MOTHER'S MAIDEN NAME Hazel Marie King				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no --			16. SOCIAL SECURITY NO. none		17. INFORMANT Address Rosewood Records, Owings Mills, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Necrotizing Bronchial Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that he (this hospital) attended the deceased from 9/18 , 19 64 , to 10/30 , 19 67 , that he (we) last saw the deceased alive on 10/30 , 19 67 , and that death occurred at 9:40 A.M. from causes and on the date stated above.									
22a. SIGNATURE <i>Richard A. Jones</i> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-31-67		
22c. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.					22d. ADDRESS Rosewood St. Hosp., Owings Mills, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1 Nov. 1967		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial			23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md. AA		
24. FUNERAL DIRECTOR <i>Donald Baker</i>					25. REC'D BY REGISTRAR <i>Richard Jones</i>		25b. REGISTRAR'S SIGNATURE <i>Richard Jones</i>		
					DATE NOV 2 1967				

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STATE OF TEXAS

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13399

CERTIFICATE OF DEATH

13402

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XXXXXX Catonsville</u>			c. LENGTH OF STAY IN 1b <u>2 1/2 Mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto,</u> 30-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shangri-La Nursing Home</u>				d. STREET ADDRESS <u>1417 Carswell Rd (18)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry W. Brengle</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>31</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/17/29</u>		9. AGE (In years last birthday) yrs. <u>88</u>	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager - Hotel</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Brengle</u>				14. MOTHER'S MAIDEN NAME <u>W.K.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>W</u>			16. SOCIAL SECURITY NO. <u>210-32-7107</u>		17. INFORMANT <u>Jos. p. Chast</u> Address <u> </u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>493X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>8/21/67</u> to <u>10/31/67</u> that (I) (we) last saw the deceased alive on <u>10/31/67</u> , and that death occurred at <u>2:00 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>David E. Zickatose</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>David E. Zickatose</u>				22d. ADDRESS <u>4 VFW Lane, Ellicott City, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/3/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. F. Zickert Sons</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

13-105

RECEIVED IN DEPT.

13331

RECEIVED IN DEPT.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13400

13403

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chesapeake Manor Nursing Home</u>				d. STREET ADDRESS <u>3825 Belair Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E.</u> Last <u>Brennan</u>				4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 19, 1904</u>		9. AGE (In years lost birthday) yrs. <u>63</u>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Electric</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas J. Brennan</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Becker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-5300</u>		17. INFORMANT Address <u>Mr. William Turner, 1209 Gleneagle Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>10-13</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10-5</u> , 19 <u>67</u> , and that death occurred at <u>5:23</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Franklin E. Leslie</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank E. Leslie M.D.</u>				22d. ADDRESS <u>302 E. 33rd St.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>				25a. REC'D BY REGISTRAR <u>OCT 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15051

UNITED STATES DEPARTMENT OF AGRICULTURE

15051

37



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13401

CERTIFICATE OF DEATH

13404

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE			c. LENGTH OF STAY IN 1b 10 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLCOTT CITY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUMMIT NURSING HOME				d. STREET ADDRESS ROCK SPRINGS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CELESTE W. BRENTANO				4. DATE OF DEATH Month Day Year OCTOBER 21 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unk 1883		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George WELLS				14. MOTHER'S MAIDEN NAME Anna Lenhart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE HEAD OF THE 157X DUE TO PANCREAS WITH WIDESPREAD (b) METASTASIS. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/11 , 19 67 , to 10/21 , 19 67 that (I) (we) last saw the deceased alive on 10/14 19 67 , and that death occurred at 6:40 A.M. from causes and on the date stated above.							
22a. SIGNATURE E. Kasa						22b. DATE SIGNED 10/21/67	
22c. PHYSICIAN'S NAME (Type) E. KASAITIS, M.D.				22d. ADDRESS 1801 FREDERICK RD, BALTIMORE MD 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/24/67		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks West Inc. Balt. Md. 21228				25a. REC'D BY REGISTRAR DATE OCT 25 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
13402.					CERTIFICATE OF DEATH					13405					
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 217 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) REISTERSTOWN					03, 1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL					d. STREET ADDRESS 222 HIGHMEADOW ROAD					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First HENRY Middle V. Last BRILLHART					4. DATE OF DEATH Month OCTOBER Day 3 Year 19 67										
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 1, 1891		9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD			10b. KIND OF BUSINESS OR INDUSTRY BREWERY		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME EDWARD BRILLHART					14. MOTHER'S MAIDEN NAME ELIZA KLIENFELTER										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16. SOCIAL SECURITY NO. WW I 217 05 21 45		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) THROMBOSIS CEREBRAL ARTERIES DUE TO ARTERIOSCLEROSIS										INTERVAL BETWEEN ONSET AND DEATH RECENT					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (X) (this hospital) attended the deceased from 2/28/67 , 19__, to 10/3/67 , 19__, that (X) (we) last saw the deceased alive on 10/3/67 , 19__, and that death occurred at 6:00A M, from causes and on the date stated above.															
22a. SIGNATURE <i>Jorge A. Fabara</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/3/67								
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.					22d. ADDRESS VAH FORT HOWARD, MARYLAND										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF Oct. 6, 1967		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND							
24. FUNERAL DIRECTOR <i>H. J. Schhardt</i>			ADDRESS ECKHARDT FUNERAL HOME		25a. REC'D BY REGISTRAR OCT 5 1967			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							
REISTERSTOWN, MARYLAND															

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13403

13407

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTIMORE COUNTY GENERAL HOSPITAL		d. STREET ADDRESS 3104 MINNA COURT #21207	
3. NAME OF DECEASED (Type or print) First RUBIN Middle R. Last BROOKS		4. DATE OF DEATH Month OCTOBER Day 3 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSTALLATION		10b. KIND OF BUSINESS OR INDUSTRY BUILDING	11. BIRTHPLACE (County & State, or foreign country) NEW YORK
13. FATHER'S NAME CHARLES BROOKS		14. MOTHER'S MAIDEN NAME SHANE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. #21207	
17. INFORMANT MRS. RENA BROOKS, 3104 MINNA CT., #21207		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE - PREVIOUS MYOCARD. INFARCT 1962 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from NOV. 1966 , to 10-3-1967 , that (I) (we) last saw the deceased alive on FEB 1966 , and that death occurred at 11:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Joseph Deckelbaum		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10-3-67
22c. PHYSICIAN'S NAME (Type) DR. JOSEPH DECKELBAUM		22d. ADDRESS 3502 W. ROGERS AVENUE	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-8-67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD.		25a. REC'D BY REGISTRAR OCT 11 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

13403

STATE OF DEATH

13403

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
AGE
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
MARRIAGE
SINGLE
MARRIED
WIDOWED
DIVORCED
REMARKS

DATE OF BIRTH
PLACE OF BIRTH
CAUSE OF BIRTH
MANNER OF BIRTH
AGE
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RACE
RELIGION
EDUCATION
OCCUPATION
MARRIAGE
SINGLE
MARRIED
WIDOWED
DIVORCED
REMARKS

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
AGE
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
MARRIAGE
SINGLE
MARRIED
WIDOWED
DIVORCED
REMARKS

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13404

13408

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CITY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>			c. LENGTH OF STAY IN TB		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTO. MEDICAL CENTRE</u>			d. STREET ADDRESS <u>708 ALLENDALE ST.</u>		
3. NAME OF DECEASED (Type or print) <u>ELIZABETH C. BROWN</u>			4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>21</u> Year <u>1967</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-30</u>	9. AGE (In years last birthday) <u>36</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>WILLIE WEST CLEMENTS</u>			14. MOTHER'S MAIDEN NAME <u>SELBY (ROBERTA)</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-20-3412</u>	17. INFORMANT <u>MR. SAMUEL BROWN</u> Address <u>708 ALLENDALE ST</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF BREAST</u> 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 18</u> , 19 <u>67</u> , to <u>Oct. 21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct. 21</u> , 19 <u>67</u> , and that death occurred at <u>9:15 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Marjorie S. Fabe</u>			22b. DATE SIGNED <u>Oct. 21, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>HNASTACIA E. FABIE</u>			22d. ADDRESS <u>Greater Baltimore Med. Center</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/25/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARBUTUS MEMORIAL PK</u>	23d. LOCATION (City or Town)	(County)	(State) <u>BALTO CO, MD</u>
24. FUNERAL DIRECTOR <u>HERBERT E. NUTTEN</u> ADDRESS <u>3035 W. NORTH AVE</u>			25a. REC'D BY REGISTRAR DATE <u>OCT 27 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Yuanes Yung</u>	

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RECEIVED OF LEAH

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CARMINA OF DECEMBER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

13405		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		13409	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS Shady Oaks Trailer Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First HARRY Middle MILTON Last BURLESON			4. DATE OF DEATH Month 10 / Day 26 / Year 1967		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/18/1909		9. AGE (In years lost birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction worker		10b. KIND OF BUSINESS OR INDUSTRY Electric		11. BIRTHPLACE (County & State, or foreign country) Mitcher Co, N. Carolina	
13. FATHER'S NAME Asa Burleson			14. MOTHER'S MAIDEN NAME Judie Greene		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 245-05-9176		17. INFORMANT Address Records at Mt. Wilson State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAIR ADVANCED PULMONARY 0021 DUE TO TUBERCULOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____ (c) DUE TO _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE BRONCHITIS, PULMONARY EMPHYSEMA					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/23/1967 , to 10/26/1967 , that (I) (we) last saw the deceased alive on 10/26/1967 , and that death occurred at 5:10 PM , from causes and on the date stated above.					
22a. SIGNATURE W. Newcomer			22b. DATE SIGNED 10-26-1967		22c. PHYSICIAN'S NAME (Type) William Newcomer, M.D.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-29-67	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL CEMETERY		23d. LOCATION (City or town) (County) (State) SPRUE PINE NC.
24. FUNERAL DIRECTOR John M. Taylor Sons Annapolis MD.			25a. REC'D BY REGISTRAR OCT 31 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jones

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13406

CERTIFICATE OF DEATH

13410

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>42 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall, Maryland</u>		d. STREET ADDRESS <u>White Hall, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balt. Med. Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen</u> First <u>Eliza</u> Middle <u>Burns</u> Last		4. DATE OF DEATH <u>10-18-1967</u> Month <u>10</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-22-04</u> 63 yrs.
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR: Months <u>10</u> Days <u>18</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>White Hall, MD.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Almon (De.)</u>		14. MOTHER'S MAIDEN NAME <u>MAYS (Priscilla Rutledge)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-32-8284</u>	
17. INFORMANT <u>Admission Sheet</u>		Address <u>Admission Sheet</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>OF EVER, UNKNOWN ETIOLOGY</u> DUE TO (b) <u>SPLENOMEGALY, UNKNOWN ETIOLOGY</u> DUE TO (c) <u>POSSIBLE LYMPHOMA</u>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ANEMIA AND ELECTROLYTE IMBALANCE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 7, 1967</u> , to <u>OCT. 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>OCT. 18, 1967</u> , and that death occurred at <u>8:17 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Manuel A. Gongon</u>		22b. DATE SIGNED <u>Oct. 18, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. MANUEL A. GONGON</u>		22d. ADDRESS <u>GBMC, TOWSON, MD 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>Oct. 24, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Vulcan Valley Mem. Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Timonium, Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>L. Jacob Hartenstein, New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 25 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13407

CERTIFICATE OF DEATH

13411

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		c. LENGTH OF STAY IN 1b <u>3 YEARS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		d. STREET ADDRESS <u>GIEN-ARM</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>VILLA MARIA - NOTCH - CLIFF</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SISTER MARY JOSIA BYRNE</u>		4. DATE OF DEATH Month <u>10</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/22/1896</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONVENT</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PATRICK BYRNE</u>		14. MOTHER'S MAIDEN NAME <u>MARY ANNE QUAIL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-54-2935-T</u>	
17. INFORMANT <u>SR. CATHERINE MARY NOTCH CLIFF</u>		Address <u>Glen-Arm Notch Cliff</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>299X Congestive Heart Failure</u> DUE TO (b) <u>Severe Anemia</u> DUE TO (c) <u>Aplastic Bone Marrow</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/5</u> , 19 <u>67</u> , to <u>10/12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/5</u> , 19 <u>67</u> , and that death occurred at <u>12:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Henry L. McConkle</u>		22b. DATE SIGNED <u>10-12-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sisters Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Arm Balt. Md.</u>
24. FUNERAL DIRECTOR <u>Raymond J. Curran</u>		25a. REC'D BY REGISTRAR <u>Charles J. J...</u>	
ADDRESS <u>817 Scarlett Dr. Towson, Maryland 21204</u>		DATE <u>OCT 20 1967</u>	

11111

CERTIFICATE OF DEATH

40127

Baker

1901

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13405

CERTIFICATE OF DEATH

13412

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 8 yrs		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md		b. COUNTY ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stella Maris Hospice				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. STREET ADDRESS 3612 Yolando Road	
3. NAME OF DECEASED (Type or print) Edward S. Carney, Sr.		First		Middle		Last		4. DATE OF DEATH Month Day Year 10/23/67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/1880	9. AGE (In years lost birthday) yrs. 87	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab worker		10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Carney				14. MOTHER'S MAIDEN NAME Elizabeth Sweeney					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 216-07-7407		17. INFORMANT Hospice records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CVA DUE TO (c) ASCVD								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/1/59 , 19__, to 10/23/67 , 19__, that (I) (we) last saw the deceased alive on 10/22/67 , 19__, and that death occurred at 2:30 AM from causes and on the date stated above.									
22a. SIGNATURE Robert J. Mahon				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/23/67			
22c. PHYSICIAN'S NAME (Type) Robert J Mahon, M.D.				22d. ADDRESS 204 E. Joppa Rd., Towson					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 25, 67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		ADDRESS 1050 York Road		25a. REC'D BY REGISTRAR Towson, Maryland 21204		25b. REGISTRAR'S SIGNATURE OCT 25 1967			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13413

CONTINUED IN DEATH

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Belmont

London

Beckie Marie Houston

London

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTO.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. LENGTH OF STAY IN 1b 14 TERRACE RD.	
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE M.D.		b. COUNTY BALTO		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX	
3. NAME OF DECEASED (Type or print) ROBERT R. CARRICK		4. DATE OF DEATH OCT. 19 1967		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 6, 1883	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. CONDUCTOR		10b. KIND OF BUSINESS OR INDUSTRY M.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK CARRICK			14. MOTHER'S MAIDEN NAME AMY HOOD		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK.		16. SOCIAL SECURITY NO. 717-07-8355		17. INFORMANT EDITH CARRICK	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V DISEASE 4221 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Senility (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH —	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) BALTO.	(County) M.D.	(State) M.D.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE M.B. DAVIS		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. DAVIS		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10/19/67	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/23/67	22c. NAME OF CEMETERY OR CREMATORY SACRED HEART	22d. LOCATION (City, town, or county) BALTO. M.D.	(State) M.D.	
23. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE		24a. REC'D BY REGISTRAR OCT 21 1967	24b. REGISTRAR'S SIGNATURE M. L. Judge

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MEDICAL EXAMINATION REPORT

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13410

13414

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 23 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 57 CALVERT STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle B. Last CARROLL		4. DATE OF DEATH Month OCTOBER Day 18 Year 19 67		5. SEX MALE		6. COLOR OR RACE NEGRO	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1/21/06		9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) KITCHEN HELPER		10b. KIND OF BUSINESS OR INDUSTRY COLLEGE		11. BIRTHPLACE (County & State, or foreign country) ANNAPOLIS, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES CARROLL				14. MOTHER'S MAIDEN NAME IRENE SMITH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 214 14 33 23		17. INFORMANT Address CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA, METASTATIC OF NECK 191.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN DEATH MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 9/25/67 , 19__ to 10/18/67 , 19__, that (X) (we) last saw the deceased alive on 10/18/67 , 19__, and that death occurred at 6:00A M, from causes on and on the date stated above.							
22a. SIGNATURE <i>George C. McElpatrick M.D.</i>				22b. DATE SIGNED 10/18/67		22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D.	
22d. ADDRESS VAH FORT HOWARD, MARYLAND				22e. ADDRESS REESE FUNERAL HOME ANNAPOLIS, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-23-1967		23c. NAME OF CEMETERY OR CREMATORY BURELL CEMETERY		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS, MD.	
24. FUNERAL DIRECTOR <i>William Reese</i>		25a. REC'D BY REGISTRAR DATE OCT 19 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			

575

CUATRO PLAN

SIGNATURE

824. 55

CASE STUDY

ADMINISTRATIVE INFORMATION

ALBANY, N.Y.

STORING

23

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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GRANTHAM, ELIO LARMA

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RESEARCH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13411

CERTIFICATE OF DEATH

13415

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore-Towson</u>		c. LENGTH OF STAY IN 1b <u>5 wks 6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix, Md. 21131</u>		03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				d. STREET ADDRESS <u>None listed</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Miles</u> Middle <u>R.</u> Last <u>Carroll, Sr.</u>				4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07-12-88</u>	9. AGE (In years lost birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner of Store</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hartford Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>J. Perry Carroll</u>				14. MOTHER'S MAIDEN NAME <u>Curry, Susannah.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-32-3349</u>		17. INFORMANT <u>Patient's Chart</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5021</u> <u>Bronchopneumonia</u> DUE TO (b) <u>Chronic Bronchitis</u> DUE TO (c) <u>Constrictive Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Prostatic Hypertrophy</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <u>2</u> (this hospital) attended the deceased from <u>8/27</u> , 19 <u>67</u> , to <u>10/7</u> , 19 <u>67</u> , that <u>2</u> (we) last saw the deceased alive on <u>10/7/67</u> , 19 <u>67</u> , and that death occurred at <u>9:35 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Duncan McGhie</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DUNCAN MCGHIE</u>				22d. ADDRESS <u>5645, Lochain Rd. Balto Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Oct. 10, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) <u>Baltimore County, Md</u>	
24. FUNERAL DIRECTOR <u>Wm Cook Brooks Towson.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1152

Brachycephalus
Chamaeleon
Crotaphytus
Geophis

10/2/62
DUNCAN
McCHIE

2017. Latham Rd. Bldg 119
10/1/17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13412

Item #8 Film #G393 10/18/67 ph

CERTIFICATE OF DEATH

13416

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		d. STREET ADDRESS 8417 Pleasant Plains Road	
3. NAME OF DECEASED (Type or print) First Alexander Middle CARSWELL, Sr. Last CARSWELL, Sr.		4. DATE OF DEATH Month October Day 12 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/23 9/23/1900
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supt. Lever Bros. Oil Refinery.		10b. KIND OF BUSINESS OR INDUSTRY Scotland	
11. BIRTHPLACE (County & State, or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander C. Carswell		14. MOTHER'S MAIDEN NAME Jessie M. McGilchrist	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 306-10-4372	
17. INFORMANT Mrs. Margaret Carswell		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Infarction DUE TO (c) Arteriosclerotic Heart Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 4201			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/12 , 19 67 , to 10/12 , 19 67 , that (I) (we) last saw the deceased alive on 10/12/ 19 67 , and that death occurred at 6P M, from causes and on the date stated above.			
22a. SIGNATURE Jaime Singzon, M.D.		22b. DATE SIGNED 10-12-67	
22c. PHYSICIAN'S NAME (Type) Jaime Singzon, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/16/67.	
23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR OCT 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1911

CONFIDENTIAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13413

CERTIFICATE OF DEATH

13417

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b Towson d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 104 E. Susquehanna Ave. #21204 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Joseph Caslin		4. DATE OF DEATH Month Day Year October 23 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1912
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Attorney at Law	
11. BIRTHPLACE (County & State, or foreign country) Texas, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick J. Caslin		14. MOTHER'S MAIDEN NAME Edna M. Harmon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 11	
17. INFORMANT Family records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis - primary site undetermined. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 15, 1967 , to October 23 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 23 19 67 , and that death occurred at 1:15 AM , from causes and on the date stated above.			
22a. SIGNATURE Reynaldo Orjuela-Gomez, M.D.		22b. DATE SIGNED 11/23/67	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 25, 1967	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial	23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		25a. REC'D BY REGISTRAR DATE OCT 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1961

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1961

REVENUE DE CHAIN

1961

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Parkville		c. LENGTH OF STAY IN lb 1 3/4 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3416 E. Joppa Rd 34		d. STREET ADDRESS 3416 E. Joppa Rd 34	
3. NAME OF DECEASED (Type or print) ALBERTA CHARLOTTE CHASE		4. DATE OF DEATH Month OCT. Day 10. Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 8, 1927
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY NONE	9. AGE (In years lost birthday) 40 yrs.
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARCHIE G. WILKINS		14. MOTHER'S MAIDEN NAME CATHERINE C. CALDWELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT C. RAYMOND McLAUGHLIN		7851 RIVERDALE RD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5810 MALNUTRITION DUE TO (b) Gastroenteritis DUE TO (c) Cirrhosis of liver			INTERVAL BETWEEN ONSET AND DEATH undet.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE JOAN C. Hyle		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOAN C. Hyle		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) 7527 Belvid Rd 36	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF OCT. 13/67	23c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE MD.
24. FUNERAL DIRECTOR H.W. MEARS & SON 805 N. CALVERT ST.		25a. REC'D BY REGISTRAR OCT 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

11

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13415

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY in 1b 44 Days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21225	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 401 E. Townsend Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HERBERT Middle CHRISTOPHER Last				4. DATE OF DEATH Month OCTOBER Day 21 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/91	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Business Bldg.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Christopher				14. MOTHER'S MAIDEN NAME Anna Blaich			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218-01-95-79		17. INFORMANT Address Clin.Rec. VA Hospital, Fort Howard, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOSARCOMA 2001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 7 , 19 67 , to Oct. 21 , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 21 , 19 67 , and that death occurred at 4:00AM from causes and on the date stated above.							
22a. SIGNATURE Elsa M. Goris M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/21/67	
22c. PHYSICIAN'S NAME (Type) ELSA M. GORIS, M.D.				22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/24/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR McCully Funeral Home				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13416

CERTIFICATE OF DEATH

13420

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b _____			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore #21218 30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 627 Parkwyth Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Frank Henderson CLARK				4. DATE OF DEATH Month Day Year October 10 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1900		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-B&O and Dept. of Recreation			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank H. Clark				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-03-1178		17. INFORMANT Mrs. Hildreth E. Clark (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary embolism & infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Intramural thrombosis DUE TO (c) Acute myocardial infarction							INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____		
21. I certify that (I) (this hospital) attended the deceased from September 16, 19 67 , to October 10 19 67 that (I) (we) last saw the deceased alive on October 10 19 67 , and that death occurred at 11:20 PM from causes and on the date stated above.							
22a. SIGNATURE <i>Elmo Gayoso</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED October 11, 1967	
22c. PHYSICIAN'S NAME (Type) Elmo Gayoso, M.D.				22d. ADDRESS 7620 York Road Towson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/14/67	23c. NAME OF CEMETERY OR CREMATORY Pipe Creek		23d. LOCATION (City or Town) (County) (State) New Windsor, Md.		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.				25a. REC'D BY REGISTRAR OCT 11 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Form with multiple sections and fields, mostly illegible due to extreme fading. Visible text includes:

- Top header area with "1951" on the left and right.
- Section headers: "GENERAL INFORMATION", "PERSONAL DATA", "EDUCATION", "EMPLOYMENT", "MILITARY SERVICE", "REFERENCES", "REMARKS".
- Form fields: Numerous rectangular boxes for data entry, many of which are empty or contain faint, illegible text.
- Bottom section: A large rectangular box labeled "REMARKS" or "COMMENTS" at the bottom right.

Item 20 Film DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
394 11-6-67 and Items #13, 14 & 23b Film #G391, 11/13/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13421

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4 c. LENGTH OF STAY IN 1b 21206 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206 d. STREET ADDRESS 4611 Ridgeway Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ina B. Clark		4. DATE OF DEATH Month Day Year October 28, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-1877
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Lehigh Valley Railroad	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Austin C. Mead		14. MOTHER'S MAIDEN NAME Francelia Woodworth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 715-16-9498	
17. INFORMANT C. Mrs Ruth Hanson		Address 4611 Ridgeway Road 6	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO (b) Fracture of Left Hip Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in bedroom at home	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 9:20 p.m. Oct. 26 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Rullerton Balto. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Cazenovia Cazenovia New York	
22. DATE SIGNED 10/28/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-1-1967	23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	23d. LOCATION (City or Town) (County) (State) Cazenovia Cazenovia New York
24. FUNERAL DIRECTOR Lassahn Funeral Home		25a. REC'D BY REGISTRAR NOV 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13418

CERTIFICATE OF DEATH

13422

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 Beaumont Ave.		d. STREET ADDRESS 14 Beaumont Ave	
3. NAME OF DECEASED (Type or print) Joseph A. Codd		4. DATE OF DEATH Month October Day 24 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1st, 1897
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 03 Days 1	11. IF UNDER 24 HRS. Hours 03 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY State Roads Comm. Maryland	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick J. Codd		14. MOTHER'S MAIDEN NAME Catherine Sinnott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-05-9587	
17. INFORMANT James Leo Codd		Address 14 Beaumont Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident DUE TO (b) Atherosclerosis DUE TO (c) year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 331X 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Stroke left them plain due to Cerebral Thrombosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug , 19 67 to Oct , 19 67 that (I) (we) last saw the deceased alive on 10/31 19 67 and that death occurred at 3P M, from causes and on the date stated above.			
22a. SIGNATURE James Nolan		22b. DATE SIGNED 10/24/67	
22c. PHYSICIAN'S NAME (Type) J J NOLAN		22d. ADDRESS Baltimore, Md. 21229	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE THEREOF Oct. 27/67	23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery	23d. LOCATION (City or town) (County) (State) Balto Md
24. FUNERAL DIRECTOR Farley Cavanaugh Funeral Home		25a. REC'D BY REGISTRAR DATE OCT 30 1967	
25b. REGISTRAR'S SIGNATURE Charles Jones			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13419

CERTIFICATE OF DEATH

13423

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holly Hill Manor		d. STREET ADDRESS 901 E. 41st St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Milton Middle E. Last Conner		4. DATE OF DEATH Month Oct. Day 7 Year 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/1894 9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Refrigeration	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 213-09-9540	
17. INFORMANT Miss Mary A. Smith		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 wks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 20, 1963 , to Oct 7, 1967 , that (I) (we) last saw the deceased alive on Oct 7, 1967 , and that death occurred at 2:45 AM , from causes and on the date stated above.			
22a. SIGNATURE Laurence C. Post		22b. DATE SIGNED 10/9/67	
22c. PHYSICIAN'S NAME (Type) Dr. Laurence C. Post		22d. ADDRESS 6805 York Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/10/1967	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR OCT 10 1967	
ADDRESS 4905 York Rd. Balto. 12, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

13420		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		13424	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY BALTO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GARRISON		c. LENGTH OF STAY IN 1b 2 Yrs 1 mo 24		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FOX LEIGH NURSING HOME		d. STREET ADDRESS 6737 WILMONT AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERTHA		First B Middle M Last CONWAY		4. DATE OF DEATH Month 10 Day 1 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-83	9. AGE (In years last birthday) yrs. 84	IF UNDER 1 YEAR Months 0 Ooys 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Charles Liebno		14. MOTHER'S MAIDEN NAME Wilhelmina Kluth	
15. WAS DECEASED EVER IN U.S. ARMOED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 416-01-7393		17. INFORMANT Address Mrs. Gwendolyn R. Pearce 511 Lucia Ave.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized (c) 10 yrs.				INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from MARCH 19, 1964 , to SEPT. 30, 1967 , that (I) (we) last saw the deceased alive on SEPT. 30, 1967 , and that death occurred at 4:10 a.m. , from causes and on the date stated above.					
22a. SIGNATURE Gilbert E. Rudman, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED OCT. 2, 1967	
22c. PHYSICIAN'S NAME (Type) GILBERT E. RUDMAN, M.D.		22d. ADDRESS 4701 LIBERTY HTS. AVE.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-3-1967		23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park	
23d. LOCATION (City or Town) (County) (State) Carroll Co., Md.					
24. FUNERAL DIRECTOR G. Howard Strong		ADDRESS 3207 W. North Ave.,		25a. REC'D BY REGISTRAR OCT 3 1967	
25b. REGISTRAR'S SIGNATURE G. Howard Strong					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13421

CERTIFICATE OF DEATH

13425

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

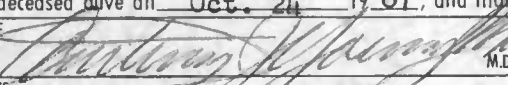
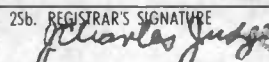
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>03-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>305 Sacred Heart Lane</u>		d. STREET ADDRESS <u>305 Sacred Heart Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Reynold</u> Middle <u>A.</u> Last <u>Cover</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>10</u> - Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 8, 1899</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>First Manteam</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>East Eboric</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harry M. Cover</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Humphreys</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>212-05-3265</u>	
17. INFORMANT <u>ROSE A COVER</u>		Address <u>305 Sacred Heart Lane</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC OBSTRUCTIVE PULMONARY EMPHYSEMA</u> 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 4, 1966</u> , to <u>OCT. 10, 1967</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>OCT. 6, 1967</u> , and that death occurred at <u>1:59 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Howard H. Gendason</u>		22b. DATE SIGNED <u>OCT. 10, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOWARD H. GENDASON MD.</u>		22d. ADDRESS <u>REISTERSTOWN, MD. (21136)</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-13-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikesville Balto Md</u>	
24. FUNERAL DIRECTOR <u>Loring Byers</u>		25. REC'D BY REGISTRAR <u>James Judge</u>	
25a. ADDRESS <u>8728 Liberty Rd Randallstown</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item #8 Film #G394 10/30/67 ph

13426

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN ID 5yr11mth11dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Julian Cox		4. DATE OF DEATH Month Day Year October 24 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889 Oct. 17, 1889
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Alexander Cox		14. MOTHER'S MAIDEN NAME Susan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 465X Pulmonary Embolism, massive, left lung IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from Nov. 13, 1967 to Oct. 24, 1967 , that he (we) last saw the deceased alive on Oct. 24, 1967 , and that death occurred at 12:20 P. M, from causes and on the date stated above.			
22a. SIGNATURE  M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-24-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/27/67	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem	23d. LOCATION (City or Town) (County) (State) A A Co Md
24. FUNERAL DIRECTOR McCully		25a. REC'D BY REGISTRAR DATE OCT 26 1967	25b. REGISTRAR'S SIGNATURE 

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

13423
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13423

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE md b. COUNTY BALTIMORE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DUNDALK		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DUNDALK	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3435 YARDLEY DRIVE		d. STREET ADDRESS 3435 YARDLEY DRIVE	
3. NAME OF DECEASED (Type or print) CARRIE HERRING CROSWELL		4. DATE OF DEATH 10/10/1967	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 15, 1890	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HOWARD CROSWELL		14. MOTHER'S MAIDEN NAME FLORENCE I. KLAUSMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. HELEN KOPPELMAN		Address 3436 YORKWAY DUNDALK	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension C.O.D. 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-16-67 to 10-16-67 , that (I) (we) last saw the deceased alive on 10-10-67 , and that death occurred at PM , from the causes and on the date stated above.			
22a. SIGNATURE Samuel J. Hankin		22b. DATE SIGNED 10-12-67	
22c. PHYSICIAN'S NAME (Type) Samuel J. Hankin, M.D.		22d. ADDRESS 3479 Liberty Pkwy. Baltimore, Md. 21222	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/13/67	
23c. NAME OF CEMETERY OR CREMATORY ORAN LAWN		23d. LOCATION (City, town or county) (State) BALTO. Co., md	
24. FUNERAL DIRECTOR'S SIGNATURE Walter H. Bradley		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Baltimore, Md		DATE OCT 16 1967	

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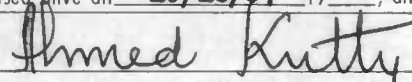
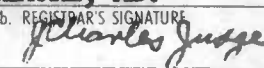
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13424

13428

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 51 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d. STREET ADDRESS 7914 33rd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE L. CUTLER			4. DATE OF DEATH Month Day Year OCTOBER 18 19 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/99		9. AGE (In years last birthday) yrs. 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATIONARY ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY NATL. BISCUIT CO.		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD.	
13. FATHER'S NAME GEORGE CUTLER			14. MOTHER'S MAIDEN NAME TERESA BODECK		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 213 01 45 46		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE WITH ATRIAL FIBRILLATION DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (a) this hospital attended the deceased from 8/26/67 , 19____, to 10/18/67 , 19____, that (b) (we) last saw the deceased alive on 10/18/67 , 19____, and that death occurred at 2:50AM from causes and on the date stated above.					
22a. SIGNATURE  AHMED C. K. KUTTY, M. D.			22b. DATE SIGNED 10/18/67		22c. PHYSICIAN'S NAME (Type) AHMED C. K. KUTTY, M. D.
22d. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/20/67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.
24. FUNERAL DIRECTOR SCHIMUNEK FUNERAL HOME 2601 E. Madison St. Baltimore, Md.			25a. REC'D BY REGISTRAR OCT 20 1967 25b. REGISTRAR'S SIGNATURE 		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEMORANDUM FOR THE DIRECTOR

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13425

CERTIFICATE OF DEATH

13429

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 13 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Zone 21228		d. STREET ADDRESS 403 Hilton Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wilhelmina Maria Dalcour		4. DATE OF DEATH Month Oct. Day 21 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1902
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 11 Days 1 Hours 24 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gustave T. Dalcour		14. MOTHER'S MAIDEN NAME Guillermina C. de Bullet	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-3131	
17. INFORMANT Mrs. Benjamin Whiteley		Address Catonsville, Md. 21228 403 Hilton Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic cerebro-cardiovascular disease 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 yr +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 19, 1956 to Oct 21, 1967 , that (I) (we) last saw the deceased alive on Oct 20, 1967 , and that death occurred at 8:34 A.M. from causes on and on the date stated above.			
22a. SIGNATURE John A. Nesbitt Jr.		22b. DATE SIGNED 10-23-67	
22c. PHYSICIAN'S NAME (Type) John A. Nesbitt Jr. M. D.		22d. ADDRESS 1009 Frederick Rd. Catonsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/24/1967	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Easton Funeral Home		25a. REC'D BY REGISTRAR OCT 27 1967	
ADDRESS Catonsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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DEPARTMENT OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13428										13430	
Items #5, 6, 8, 9 & 12 Film #G393 10710/67											
1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Nursing Home</u>						d. STREET ADDRESS <u>Box 439-A, Route 1</u>					
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>DAUGHTERTY</u> Last						4. DATE OF DEATH Month <u>10</u> - Day <u>3</u> - Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 1, 1898</u>		9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence Albert Harrison</u>						14. MOTHER'S MAIOMEN NAME <u>Poxie Adali Mathaney</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Paresis - CNS Les (Latent)</u>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July, 1959</u> to <u>10-3-1967</u> , that (I) (we) last saw the deceased alive on <u>10-3-1967</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Cesar Valle Cauero</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-3-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAUERO</u>						22d. ADDRESS <u>8629 Liberty Rd</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>10-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Anselm's Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Frank A. Muel</u>						25a. REC'D BY REGISTRAR <u>Oct 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
13427					13431									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY <u>Baltimore</u>					a. STATE <u>Md</u> b. COUNTY <u>1</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore Md</u>									
c. LENGTH OF STAY IN 1b <u>30-4</u>					d. STREET ADDRESS <u>417 Athol Ave</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shady Nook Nursing Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First <u>Mary</u> Middle <u>Beatrice</u> Last <u>Davis</u>					Month <u>10</u> Day <u>12</u> Year <u>1967</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 12 1882</u>		9. AGE (In years last birthday) <u>85</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Westminster Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>12</u> Hours <u>19</u> Min. <u>67</u>						
13. FATHER'S NAME <u>F. Charles Eckenrode</u>					14. MOTHER'S MAIDEN NAME <u>Mary Ellen Logue</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>216 54 6339J1</u>					17. INFORMANT <u>Mrs. WM. J. C. Smith</u> Address <u>103 C Rolling Bend Rd.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4201 DUE TO <u>atherosclerotic cerebro-cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>disease</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>1 yr +</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 3</u> , 19 <u>67</u> , to <u>Oct 12</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-6-67</u> 19 <u>67</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.														
22a. SIGNATURE <u>John A. Nesbitt, Jr.</u>						22b. DATE SIGNED <u>10-13-67</u>		22c. PHYSICIAN'S NAME (Type) <u>John A. Nesbitt, Jr., M.D.</u>						
22d. ADDRESS <u>1009 Frederick Road, Baltimore, Md.</u>						22e. REC'D BY REGISTRAR <u>OCT 16 1967</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 14 - 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						
24. FUNERAL DIRECTOR <u>Farley Cavanaugh Funeral Home</u>						25a. ADDRESS <u>6601 Frederick Ave</u>								

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13428

13432

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY 30-y			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORT HOWARD			c. LENGTH OF STAY IN IB 37 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 50 S. MORLEY STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MELVIN Middle WARNER Last DE SHIELDS				4. DATE OF DEATH Month OCTOBER Day 4 Year 19 67			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/28/16		9. AGE (In years last birthday) yrs. 51	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTENDANT			10b. KIND OF BUSINESS OR INDUSTRY PARKING LOT		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES DeSHIELDS				14. MOTHER'S MAIDEN NAME MABEL CAMPER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 212 07 05 97		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GLIOBLASTOMA GRADE IV 1939 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONIA						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (*) (this hospital) attended the deceased from 8/28/67 , 19__, to 10/4/67 , 19__, that (*) (we) last saw the deceased alive on 10/4/67 , 19__, and that death occurred at 2:10PM from causes and on the date stated above.							
22a. SIGNATURE <i>George C. McElpatrick</i> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 10/4/67			
22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/19/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>Williams Funeral Home</i>		ADDRESS WILLIAMS FUNERAL HOME		25a. REC'D BY REGISTRAR OCT 6 1967		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>	
379 SHRODER ST. BALTIMORE, MD.							

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CERTIFICATE OF DEATH

13433

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgeway Manor Nursing Home</u>		d. STREET ADDRESS <u>4627 Magnolia Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Inez</u> First <u>M.</u> Middle <u>DeVill</u> Last		4. DATE OF DEATH <u>Oct 18</u> Month <u>19</u> Day <u>67</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/1888</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Editor Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O R.R.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Oregon</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eugene Davis</u>		14. MOTHER'S MAIDEN NAME <u>Rene ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>A 811 4 32</u>	
17. INFORMANT <u>Mr. Edward DeVille- Sparks, Maryland</u>		Address <u>Yeoho Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>arteriosclerosis generalized</u> DUE TO <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> <u>9 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Hypertension Cardiovascular Disease. Stroke 1960</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>60</u> , to <u>Oct 18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 20</u> , 19 <u>67</u> , and that death occurred at <u>4:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>A. Bradley Daugharthy, M.D.</u>		22b. DATE SIGNED <u>10-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Thompson R. Daugharthy</u>		22d. ADDRESS <u>1204 St. Francis Ave., Halethorpe</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/21/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Leonard J Ruck Inc. 5305 Harford Rd.</u>		25a. REC'D BY REGISTRAR <u>OCT 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11111

CERTIFICATE OF DEATH

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1932

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13430

13434

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b U	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balto. Beltway 1695 1/4 ml. N. of Alto		d. STREET ADDRESS 646 Plymouth Rd.	
3. NAME OF DECEASED (Type or print) WILLIAM FRANCIS DIEM		4. DATE OF DEATH October 6 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Bendix Corp.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert M. Diem		14. MOTHER'S MAIDEN NAME Ruth E. Stark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 265-62-2000	
17. INFORMANT Robert A. Diem		Address 1006 Cedarcroft Rd 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 8161			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject into auto into tractor trailer	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 1:20 XXX 10 6 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Street		20f. (City or town) Balto. (County) Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson		22. DATE SIGNED October 6, 1967	
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 9, 1967	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	23d. LOCATION (City or Town) Baltimore, Maryland (County) (State)
24. FUNERAL DIRECTOR Dippel Bro's Inc. 7110 Belair Rd. 21206		25a. REC'D BY REGISTRAR OCT 10 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

1941

WINTER - FEBRUARY 1941

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13431

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13435

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OVERLEA</u>		c. LENGTH OF STAY IN TB <u>70 YRS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4321 KENWOOD AVE</u>		d. STREET ADDRESS <u>4321 KENWOOD AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>THOMAS</u> Last <u>DIETEL</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/1883</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRODUCE SALESMAN MARKET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GERMANY</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>KUNIGUNDA GEBHARDT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>212-03-270</u>	
17. INFORMANT <u>MRS. ELIZABETH LENSCH</u>		Address <u>4321 KENWOOD AVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardiovascular Disease</u> DUE TO (b) <u>Generalized Arterio Sclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>many years</u> <u>1</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July, 1946</u> , to <u>OCT 5, 1967</u> that (I) (we) last saw the deceased alive on <u>9-21 1967</u> , and that death occurred at <u>8 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Max R. English MD.</u>		22b. DATE SIGNED <u>10-6-67</u>	22c. PHYSICIAN'S NAME (Type) <u>Max R. English MD.</u>
22d. ADDRESS <u>5713 Belair Rd Baltimore Md 21206</u>		22e. REC'D BY REGISTRAR DATE <u>OCT 9 1967</u>	
22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE THEREOF <u>OCT 9, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEM.</u>	
23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD</u>		24. FUNERAL DIRECTOR <u>Loessahn Funeral Home 7401 Belair Rd.</u>	

effect:

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

MD 2 1 M 38 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13432

13436

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b Baltimore 21213			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 2006 E. Preston St.			
3. NAME OF DECEASED (Type or print) First Isaiah Middle DIGGS Last DIGGS				4. DATE OF DEATH Month October Day 24 Year 1967			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1899		9. AGE (In years lost birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 6 Days 24 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Spawners Point		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Diggs				14. MOTHER'S MAIDEN NAME Mary Glaston			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 223-16-9338		17. INFORMANT Ureather Diggs - Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary thrombo embolism						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that NO (this hospital) attended the deceased from 9/22/ , 19 67 , to 10/24/ , 19 67 that 4 (we) last saw the deceased alive on 10/24/ , 19 67 , and that death occurred at 2:20 PM , from causes and on the date stated above.							
22a. SIGNATURE Reynaldo Orjuela-Gomez, M.D.				22b. DATE SIGNED October 24, 1967		22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 28, 1967		23c. NAME OF CEMETERY OR CREMATORY Not known		23d. LOCATION (City or Town) (County) (State) Balto Md	
24. FUNERAL DIRECTOR Charles Wilson 1000 Crescent Ave				25a. REC'D BY REGISTRAR OCT 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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RECEIVED

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Handwritten notes and stamps on the right margin, including a large "OK" and other illegible markings.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13433

CERTIFICATE OF DEATH

13437

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Milford Manor Nursing Home</u>		d. STREET ADDRESS <u>3712 DOLFIELD AVENUE</u>	
3. NAME OF DECEASED (Type or print) <u>IDA</u> Middle <u>DOLINSKY</u> Last		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	9. AGE (In years lost birthday) <u>82</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOUIS GREEN</u>		14. MOTHER'S MAIDEN NAME <u>YETTA ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>SAM DOLINE, 3107 RUECKERT AVE., #21214</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>334X</u> IMMEDIATE CAUSE (a) <u>General & Cerebral arteriosclerosis</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1967</u> , 19 <u>—</u> , to <u>10/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/11/67</u> , 19 <u>—</u> , and that death occurred at <u>5A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Milton Kirsh</u>		22b. DATE SIGNED <u>10/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MILTON KIRSH</u>		22d. ADDRESS <u>4000 W. NORTHERN PARKWAY</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-16-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 19 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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REPUBLIC OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13434

CERTIFICATE OF DEATH

13438

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 37 days		d. STREET ADDRESS 117 S Monroe St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLIFTON		4. DATE OF DEATH Month October Day 13 Year 19 67	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 18, 1905	
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Body and Fender work		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE (County & State, or foreign country) Woodbine, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur C. Dorsey		14. MOTHER'S MAIDEN NAME Minnie Shipley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-11		16. SOCIAL SECURITY NO. 214 01 95 30	
17. INFORMANT Clinical Reds VA Hospital, Fort Howard Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF RECTUM 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ADENOCARCINOMA METASTATIC RIGHT FEMUR DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that NO (this hospital) attended the deceased from Sept. 6 , 19 67 to Oct. 13 , 19 67 , that (if we) last saw the deceased alive on Oct. 13 , 19 67 , and that death occurred at 10:40 A.M. from causes and on the date stated above.		22a. SIGNATURE Madhav D. Barhanpurkar M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED 10/13/67		22c. PHYSICIAN'S NAME (Type) MADHAV D. BARHANPURKAR, M.D.	
22d. ADDRESS VA Hospital, Fort Howard, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 10-16-67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National	
23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		24. FUNERAL DIRECTOR John R. Slack ELGINOTHAM-SLACK FUNERAL HOME	
25a. REC'D BY REGISTRAR OCT 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

13425

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Oct. 11, 1943

Kate White

Woodland, Maryland

Automobile

Body and Packer work

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Arthur C. Borey

Oct 21 22 30 Clinical Note VA Hospital, Fort Howard, Md.

Yes No-11

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13435

CERTIFICATE OF DEATH

13439

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write nearest city or town) Catonsville - 28, Md.				c. LENGTH OF STAY IN 1b since Nov. 23, 55 - Baltimore City - 22, Md. Dundalk			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS 46 S. Dundalk Avenue .			
3. NAME OF DECEASED (Type or print) Mary G. Duffin				4. DATE OF DEATH Month Oct. Day 8 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1897		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel O. Caulk				14. MOTHER'S MAIDEN NAME Gertrude Flint Mathaney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-12-1926		17. INFORMANT Spring Grove Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure (immediate) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (abnormal EKG) DUE TO (c) Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recovering from Right Lobar pneumonia (Sept. 14 - 26, 1967.)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operated on Sep. 5, 1967 Comminuted Intertrochanteric Fracture of Rt. Femur (July 29)					1967
20c. TIME OF INJURY Month, Day, Year July 29, 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dr. J. Frederick, coroner released the body		20f. (City or town) (County) (State) 1967	
21. I certify that (I) (this hospital) attended the deceased from Nov. 23, 19 55 , to Oct. 8, 1967 , that (I) (we) last saw the deceased alive on Oct. 8, 19 67 , and that death occurred at 1 P M, from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Oct. 8, 1967	
22c. PHYSICIAN'S NAME (Type) Imre Kopits, M.D.				22d. ADDRESS Spring Grove State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/11/67		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk. Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR DATE OCT 11 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

John A. Smith, 1915 Wynn Ave., Honolulu, Mo.

Barley 10/11/67

Wendland, Kansas, Mo.

Baltimore, Mo.

1915 Wynn Ave., N.D. Spring Grove State Hospital

1915 Wynn Ave.

Oct. 19

Nov. 23

Oct. 19

Oct. 19

Dr. J. E. Smith, 1915 Wynn Ave., N.D.

July 29

1915 Wynn Ave., N.D. (1915 Wynn Ave., N.D.)

Recovering from right lung pneumonia (1915 Wynn Ave., N.D.)

Generalized atelectasis

Arteriosclerotic heart disease (1915 Wynn Ave., N.D.)

Acute heart failure (1915 Wynn Ave., N.D.)

212-12-1250 Spring Grove Hospital

Harold O. Smith

Harold O. Smith

Harold O. Smith

Harold O. Smith

Female - white

July 2, 1915

Male

July 2, 1915

Oct. 19

Oct. 19

1915 Wynn Ave., N.D. - Baltimore, Mo. - 1915 Wynn Ave., N.D.

Smith, O. Wynn

Harold O. Smith

Baltimore

1915 Wynn Ave.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13436

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13440

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTO. BELTWAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX 21221	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 313 LORRAINE AVE	
3. NAME OF DECEASED (Type or print) First WALLIS Middle WOODROW Last DUNHAM		4. DATE OF DEATH Month OCT. Day 25 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-26-1916
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Sinia Hospital	
11. BIRTHPLACE (State or foreign country) Leon W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME A L.C Dunham		14. MOTHER'S MAIDEN NAME Lucy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 232-28-7280	
17. INFORMANT Mrs Emma V. Dunham		Address 313 Lorraine Avenue Essex 21221	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William A. Pillsbury M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, City, County, State) Baltimore Co. Md.	
22. DATE SIGNED 10/27/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-30-1967	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.	
24. FUNERAL DIRECTOR Lassala Funeral Home 7401 Belair Road		25a. REC'D BY REGISTRAR DATE OCT 30 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form 1. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13437

13441

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b Arbutus	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4749 Westland Blvd.		d. STREET ADDRESS 4749 Westland Blvd.	
3. NAME OF DECEASED (Type or print) ELEANOR MARY DUVALL		4. DATE OF DEATH October 12, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-4-1893
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Kotmair	
14. MOTHER'S MAIDEN NAME Rachael		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Mearle D. Duvall, 3009 Savoy Lane, Bowie Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - Vascular Disease 4271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE J. N. Frederick m.d.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) J. N. Frederick m.d.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) 134 Francis Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-16-67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue		25a. REC'D BY REGISTRAR 21229	25b. REGISTRAR'S SIGNATURE Oct 16 1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13438

CERTIFICATE OF DEATH

13442

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> 03-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box 255 Falls Road</u>		d. STREET ADDRESS <u>Box 255 Falls Road</u>	
3. NAME OF DECEASED (Type or print) <u>Mildred Doris Edwards</u>		4. DATE OF DEATH <u>October 23,</u> 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1913</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Earl Powell</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Agnes Alban</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST.</u> 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CANCER OF THE LUNG & BRAIN METASTASIS</u> (c) <u>Months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 29, 1967</u> , to <u>October 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>October 23, 1967</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Guillermo I. Gonzalez</u>		22b. DATE SIGNED <u>October 24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>GUILLERMO I. GONZALEZ MD</u>		22d. ADDRESS <u>10634 York Rd. Cockeysville Md. 21030</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 26, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Cockeysville, Maryland</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR <u>ACT 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1913

CERTIFICATE OF DEATH

2

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH, AND IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, CITY OF NEW YORK, OR IN THE OFFICE OF THE REGISTRAR OF DEATHS, COUNTY OF NEW YORK, OR IN THE OFFICE OF THE REGISTRAR OF DEATHS, STATE OF NEW YORK, OR IN THE OFFICE OF THE REGISTRAR OF DEATHS, DISTRICT OF COLUMBIA, OR IN THE OFFICE OF THE REGISTRAR OF DEATHS, ANY OTHER DISTRICT OR TERRITORY OF THE UNITED STATES, OR IN THE OFFICE OF THE REGISTRAR OF DEATHS, ANY FOREIGN COUNTRY, OR IN THE OFFICE OF THE REGISTRAR OF DEATHS, ANY OTHER PLACE WHERE DEATHS ARE REGISTERED.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal; and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13433

13443

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md. b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital				d. STREET ADDRESS 5940 Sunset Ave. 21207		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rosario ELARDO				4. DATE OF DEATH Month Oct. Day 14 Year 19 67			
5. SEX Male	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1883		9. AGE (In years lost birthday) 83 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? ITALY	
13. FATHER'S NAME -----				14. MOTHER'S MAIDEN NAME -----			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-10-1226A		17. INFORMANT Harry R. Elardo 5940 Sunset Ave. - 21207		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9040 DUE TO Pulmonary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Pneumonia DUE TO (c) Fractured Femur						INTERVAL BETWEEN ONSET AND DEATH 4 Days 8 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall at home in apparent confusion			
20c. TIME OF INJURY Month, Day, Year Hour a.m. (p.m.) Oct 5, 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell		EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 10/14/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/18/67		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.				25a. REC'D BY REGISTRAR OCT 17 1967		25b. REGISTRAR'S SIGNATURE Charles J. Judge	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13440

13444

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY — ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 304		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital (D.O.A.)				d. STREET ADDRESS 601 E. 41st St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Miss Agnes C Engers				4. DATE OF DEATH October 18 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/20/1890	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress - Ret.				10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles Engers				14. MOTHER'S MAIDEN NAME Anna Gier			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 216 24 0622		17. INFORMANT John A. Engers- Address 288 Bloomsbury Ave. Balto., Md. 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/21/67		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #14				25a. REC'D BY REGISTRAR OCT 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
350D 4-64

<div style="display: flex; justify-content: space-between;"> <div> <p>13441</p> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> </div> <div> <p>13445</p> </div> </div>											
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Baltimore</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u></p> <p>c. LENGTH OF STAY IN 1b <u>Minutes</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mt. Carmel Rd</u></p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u></p> <p>d. STREET ADDRESS <u>York Rd.</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					
<p>3. NAME OF DECEASED (Type or print) <u>MARION BENJAMIN ENSOR</u></p> <p>First Middle Last</p>						<p>4. DATE OF DEATH <u>Oct. 23</u> 19 <u>67</u></p> <p>Month Day Year</p>					
<p>5. SEX <u>M</u></p>		<p>6. COLOR OR RACE <u>W</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>April 23, 1902</u></p>		<p>9. AGE (In years last birthday) <u>65</u> yrs.</p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>			
<p>13. FATHER'S NAME <u>William S. Ensor</u></p>						<p>14. MOTHER'S MAIDEN NAME <u>Minnie Hollingshead</u></p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</p>						<p>16. SOCIAL SECURITY NO. <u>213-28-6247</u></p>					
<p>17. INFORMANT <u>Charles W Ensor</u></p>						<p>Address <u>Parkton, Md - 21120</u></p>					
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>MULTIPLE TRAUMATIC INJURIES</u></p> <p>8254</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>DUE TO (b) _____</p> <p>DUE TO (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)</p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>											
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Mobile injury</u></p>							
<p>20c. TIME OF INJURY Month, Day, Year <u>10</u> Hour a.m. <u>10/23</u> 19 <u>67</u></p>				<p>20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work</p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u></p>		<p>20f. (City or town) (County) (State) <u>BALTO. Md</u></p>			
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>											
<p>ACTUAL SIGNATURE <u>A. M. France</u></p>						<p>M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>					
<p>EXAMINER'S NAME (Type) <u>A. M. FRANCE</u></p>						<p>Address (Street, city, town, or county) _____</p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>				<p>23b. DATE THEREOF <u>Oct. 25, 1967</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Stablers Cemetery</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>Parkton, Md.</u></p>			
<p>24. FUNERAL DIRECTOR <u>Jacob Hartenstein, New Freedom, Pa.</u></p>						<p>25a. REC'D BY REGISTRAR <u>OCT 27 1967</u></p>		<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

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13442

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13446

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GATHISON</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOPPA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FOXLEIGH Nursing Home</u>				d. STREET ADDRESS <u>1705 HINES LANE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIE S EVANS</u>				4. DATE OF DEATH Month Day Year <u>10 22 19 67</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-20-1900</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Ennice, N.C. Moex</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ennice, N.C. Moex</u>	
13. FATHER'S NAME <u>John Tompkins</u>				14. MOTHER'S MAIDEN NAME <u>Bid Sue Whittaker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>239-18-9077B2</u>		17. INFORMANT Address <u>Gwyn Evans, Rt. 2, Darlington, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>cardiomegaly</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral Vascular Accident August 1967</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-11</u> , 19 <u>67</u> , to <u>10-22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-22</u> , 19 <u>67</u> , and that death occurred at <u>11:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>David I. Miller</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>David I. Miller</u>				22d. ADDRESS <u>Lisbon Rd - Owings Mills, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>Oct. 23, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Reins-Sturdivant F.H.</u>		23d. LOCATION (City or Town) (County) (State) <u>Sparta N.C.</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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STANDARD FORM NO. 64

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Baltimore #21213	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 3136 Kenyon Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph A. FANGMAN		4. DATE OF DEATH Month Day Year October 13 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1914
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 30 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Balto. Gas & Elec.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anthony Fangman		14. MOTHER'S MAIDEN NAME Blanche ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. 212-09-7156	
17. INFORMANT Mrs. Hilda R. Fangman		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoma of the left leg (amputated) 1991 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis to the abdomen, lungs, and brain DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from August 26, 1967 , to October 13, 1967 , that (I) (we) last saw the deceased alive on October 13, 1967 , and that death occurred at 11:30 PM from causes and on the date stated above.		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE Anibal Escobar		22b. DATE SIGNED October 14, 1967	
22c. PHYSICIAN'S NAME (Type) Anibal Escobar, M.D.		22d. ADDRESS 7620 York Road Towson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/67.	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leona rd J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE OCT 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF DEATH

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Blanchard

Anthony L. Blanchard

Driver

(100)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13444
13448
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 81 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER		e. STREET ADDRESS 7209 Waldman Avenue	
3. NAME OF DECEASED (Type or print) First MARTHA Middle Willis Last FARRIS		4. DATE OF DEATH Month October Day 18 Year 1967	
5. SEX Female	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/13
9. AGE (in years last birthday) 54 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Horatio Dawson		14. MOTHER'S MAIDEN NAME Clara V. Dawson (Youngblood)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-52-0828	
17. INFORMANT (Husband) Mr. Marion Farris, 7209 Waldman Ave.		Address Edgemere, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Respiratory failure 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic cancer of breast DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/30 , 19 67 , to 10/18 , 19 67 , that (I) (we) last saw the deceased alive on 10/18 , 19 67 , and that death occurred at 6:48 M, from the causes and on the date stated above.			
22a. SIGNATURE P. Navidi		22b. DATE SIGNED 10/18/67	
22c. PHYSICIAN'S NAME (Type) Dr. P. Navidi		22d. ADDRESS Greater Balto. Medical Center, Towson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 21, 1967	
23c. NAME OF CEMETERY OR CREMATORY Mount Nebo Cemetery		23d. LOCATION (City, town or county) (State) Berkeley Springs, W. Va.	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR OCT 23 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13445

13449

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b Hours ?	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lynch Cove Marina, 1915 Wills Rd.		d. STREET ADDRESS 7739 Wynbrook Road	
3. NAME OF DECEASED (Type or print) First John Middle H. Last Fink		4. DATE OF DEATH Month October Day 28 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1921
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 03 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman		10b. KIND OF BUSINESS OR INDUSTRY Co. Western Stevedoring	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ? Fink		14. MOTHER'S MAIDEN NAME Ruth Turner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 213-16-5807	
17. INFORMANT (Name) Mrs. Catherine Fink		Address Dundalk, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 976X IMMEDIATE CAUSE (a) Gun shot wound, Thru DUE TO (b) Anterior Head (left to right) c DUE TO (c) 25 cal pistol Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot through head	
20c. TIME OF INJURY Month Oct Day 27 Year 19 67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boat	20f. (City or town) (County) (State) Lynch Cove - Balt. Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M B Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Morningson Rd.	
EXAMINER'S NAME (Type) Melvin B. Davis		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dundalk, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/67	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR DATE OCT 31 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

13446

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13450

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton		c. LENGTH OF STAY IN 1b Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Falls Road at Pipeline		d. STREET ADDRESS Pechenial Farms	
3. NAME OF DECEASED (Type or print) First THOMAS Middle EDWARD Last FINNERTY		4. DATE OF DEATH Month October Day 20 , 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-1943
9. AGE (In years last birthday) 23 yrs.		10. IF UNDER 1 YEAR Months 23 Days 23 Hours 23 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas C. Finnerty		14. MOTHER'S MAIDEN NAME Lorraine M. Barron Barron	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Edward A. Barron, 107 Osborne Ave. 21228	
17. INFORMANT Edward A. Barron, 107 Osborne Ave. 21228		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Cerebrospinal Injuries 8214 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of motorcycle spun around and crashed into ditch	
20c. TIME OF INJURY Month, Day, Year 6:10 XXXX p.m. 10/20 1967		20d. INJURY OCCURRED 2 While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Baltimore, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 10/21/67	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-24-67	
23c. NAME OF CEMETERY OR CREMATORY Holy Rosary		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.		25a. REC'D BY REGISTRAR DATE OCT 26 1967	
		25b. REGISTRAR'S SIGNATURE Richard Judge	

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FOR STATE
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

13447

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13451

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton (Baltimore)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton - Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7611 Fitch Lane 21236</u>		d. STREET ADDRESS <u>7611 Fitch Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Edward</u> Last <u>Fitch</u>		4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 14, 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>	9. AGE (In years last birthday) <u>88</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>BALTO Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>JOHN B. Fitch</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Sipple</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-22-5456</u>	
17. INFORMANT <u>Mary E. Fitch</u>		Address <u>7611 Fitch Lane 21236</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Other sclerotic Cardio Vascular Disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>21236</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus & Anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John C. Hyle</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>7517 Belair Rd. 36</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Fullerton Balto. Md.</u>
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>		25a. REC'D BY REGISTRAR <u>1967</u>	
ADDRESS <u>7401 Belair Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13448

CERTIFICATE OF DEATH

13452

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b 16 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1802 Clermont Ct.		d. STREET ADDRESS 1802 Clermont Ct.	
3. NAME OF DECEASED (Type or print) Marie Pauline Flesher First Middle Last		4. DATE OF DEATH Oct. 30, 67 Month Day Year	
5. SEX F	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-7-1883
9. AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Leon Michails	
14. MOTHER'S MAIDEN NAME Martha VonBushnar		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Dr. E.E. Flesher, Lutherville, Md. 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic, generalized arteriosclerosis DUE TO (c) cerebral edema			INTERVAL BETWEEN ONSET AND DEATH 3 mons. 2 mons. 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) arteriosclerotic cardio vascular disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (II) (this hospital) attended the deceased from March 7, 1964 , to October 30, 1967 , that (I) (we) last saw the deceased alive on October 28, 1967 and that death occurred at 3:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Donald O. Wood, M.D.		22b. DATE SIGNED 10-30-67	
22c. PHYSICIAN'S NAME (Type) DONALD O. WOOD, M.D.		22d. ADDRESS York Rd. Timonium, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov. 1, 67	Dulaney Valley	Cockeysville, Md. Balto.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204		25a. REC'D BY REGISTRAR DATE NOV 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13453

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIKESVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MILFORD MANOR NURSING HOME		d. STREET ADDRESS 4023 NORFOLK AVENUE	
3. NAME OF DECEASED (Type or print) First RACHEL Middle Last FLOM		4. DATE OF DEATH Month OCTOBER Day 5 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (County & State, or foreign country) RUSSIA
13. FATHER'S NAME MORRIS FOOKSMAN		14. MOTHER'S MAIDEN NAME YETTA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. HILDA LIBOV		7121 PARK HEIGHTS AVE., APT. 304 APT. 304	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic bronchitis			INTERVAL BETWEEN ONSET AND DEATH 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb , 19 64 to Oct 5 , 19 67 that (I) (we) last saw the deceased alive on 10-2 19 67 , and that death occurred at 1:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. Irving Sauber M.D.		22b. DATE SIGNED 10-6-67	
22c. PHYSICIAN'S NAME (Type) DR. IRVING SAUBER		22d. ADDRESS 6905 PARK HEIGHTS AVENUE	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-8-67	23c. NAME OF CEMETERY OR CREMATORY SHOMREI MISHMERES	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD.		25a. REC'D BY REGISTRAR OCT 11 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13450

13454

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUMMIT HOME</u>		d. STREET ADDRESS <u>35 MELVIN AVE</u>	
3. NAME OF DECEASED (Type or print) <u>ALFRED M. FORT</u> First Middle Last		4. DATE OF DEATH <u>OCT. 4</u> 19 <u>67</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/2/93</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENG.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RET.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL J. FORT</u>		14. MOTHER'S MAIDEN NAME <u>WETHERBEE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WW II</u>		16. SOCIAL SECURITY NO. <u>219018628</u>	
17. INFORMANT <u>ADELE J. FORT</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of St. Lung</u> <u>163 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic cardiovascular disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> , to <u>Oct 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 30</u> 19 <u>67</u> , and that death occurred at <u>6:10 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John A. Nesbitt Jr</u>		22b. DATE SIGNED <u>10-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT JR</u>		22d. ADDRESS <u>1009 Frederick Rd. Baltimore Md 21228</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/6/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD</u>	
24. FUNERAL DIRECTOR <u>E.S. MACNABB</u>		25a. REC'D BY REGISTRAR <u>OCT 10 1967</u>	
ADDRESS <u>301 FREDERICK RD 21228</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10-10-1

10-10-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>PIKESVILLE</i> c. LENGTH OF STAY IN 1b <i>61 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Milford Manor Nursing Home</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>BALTO</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>BALTO.</i> d. STREET ADDRESS <i>130 SLADE AVENUE, APT. 407</i>	
3. NAME OF DECEASED (Type or print) First <i>May</i> Middle <i>ZELICK</i> Last <i>FRAHM</i>		4. DATE OF DEATH Month <i>10</i> Day <i>5</i> Year <i>1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-21-1891</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SALESMAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>MACHINERY</i>	11. BIRTHPLACE (County & State, or foreign country) <i>LITHUANIA</i>
13. FATHER'S NAME <i>ALFRED LEWIS FRAHM</i>		14. MOTHER'S MAIDEN NAME <i>SARAH</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>213-09-8648B</i>	
17. INFORMANT <i>MRS. YETTA FRAHM</i>		Address <i>130 SLADE AVE., APT. 407</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro Vascular insult</i> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Parkinsonism, Gaucher's D.s</i> DUE TO (c) <i>ASHD, Cat bladder kidney inf.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8</i> , 19 <i>67</i> , to <i>10/5</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>10/4</i> , 19 <i>67</i> , and that death occurred at <i>7:30</i> M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Leonard M. Hister</i>		22b. DATE SIGNED <i>10/5/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Leonard M. Hister M.D.</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>10-8-67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>HEBREW YOUNG MENS</i>		23d. LOCATION (City, town or county) (State) <i>BALTIMORE, MARYLAND</i>	
24. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD.</i>		25a. REC'D BY REGISTRAR <i>OCT 11 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13452

13457

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ridgeway Manor Nursing Home		d. STREET ADDRESS 102 Washington Street	
3. NAME OF DECEASED (Type or print) HENRY H. FREEMAN SR.		4. DATE OF DEATH Month OCT. Day 3 Year 1967	
5. SEX Male	6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1874
9. AGE (In years lost birthday) 93 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Baltimore City	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME XXXXXXXXXXXX John F. Freeman		14. MOTHER'S MAIDEN NAME Christina Henft	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Spanish-American War		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Ira L. Freeman		Address Same as 2 D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Cardio Vasc. Disease - 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from OCT. 26, 1967 , to OCT 3, 1967 , that (I) (we) last saw the deceased alive on OCT 2, 1967 , and that death occurred at 5:54 A.M. , from causes and on the date stated above.			
22a. SIGNATURE HARRY L. KNIPP, M.D.		22b. DATE SIGNED 10-3-67	
22c. PHYSICIAN'S NAME (Type) HARRY L. KNIPP, M.D.		22d. ADDRESS 4116 Edmondson Ave. Balt, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-6-67	23c. NAME OF CEMETERY OR CREMATORY Louisa Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Maryland
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc.		25a. REC'D BY REGISTRAR OCT 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF TEXAS

County of _____
City of _____
I, _____
do hereby certify that _____
is the owner of _____
and is entitled to the same.

Witness my hand and seal this _____ day of _____
1915.

Notary Public for the State of Texas.
My commission expires _____

Subscribed and sworn to before me this _____ day of _____
1915.

Notary Public for the State of Texas.

My commission expires _____

Subscribed and sworn to before me this _____ day of _____
1915.

Notary Public for the State of Texas.

My commission expires _____

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13453

CERTIFICATE OF DEATH

13458

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN lb <u>2 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chapel Hill Nursing Home</u>		d. STREET ADDRESS <u>3525 Meadowside Rd #7</u>	
3. NAME OF DECEASED (Type or print) <u>JESSIE C. FREY</u>		4. DATE OF DEATH Month <u>10</u> Day <u>-6</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-2-1903</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>3</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner - Paper Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Lancaster, Pa.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Jacob Frey</u>		14. MOTHER'S MAIDEN NAME <u>Bitzberger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212-07-4381</u>	
17. INFORMANT <u>J. Catherine Bishop</u>		Address <u>6111 Bellona Ave #12</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>5271 Pulmonary Insufficiency, Emphysema</u> IMMEDIATE CAUSE (a) <u>Cor Pulmonale, Progressive</u> DUE TO (b) <u>Progressive</u> DUE TO (c) <u>Progressive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1, 1967</u> to <u>Oct 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 5, 1967</u> , and that death occurred at <u>3p</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Daniel Bakal</u>		22b. DATE SIGNED <u>10-6-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-9-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>
24. FUNERAL DIRECTOR <u>Elkworth Armacost</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 9 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13454

13459

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MO. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7 FIR DR.		d. STREET ADDRESS 7 FIR DR.	
3. NAME OF DECEASED (Type or print) EVERETT M. FRIEND		4. DATE OF DEATH Month OCT. Day 20 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 19, 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY BANK	9. AGE (In years last birthday) 62 yrs.
11. BIRTHPLACE (State or foreign country) MO.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPHUS FRIEND		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-01-9254	
17. INFORMANT RUBY FRIEND		Address 7 FIR DR.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 8 a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Theo C. Patterson EXAMINER'S NAME (Type) THEO C. PATTERSON		22. DATE SIGNED 10/24/67	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10/23/67	23c. NAME OF CEMETERY OR CREMATORY STEELE	23d. LOCATION (City or Town) (County) (State) FRIENDSVILLE MO.
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		25. REC'D BY REGISTRAR OCT 24 1967	
25b. REGISTRAR'S SIGNATURE McMulla, Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13455

13460

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>unk</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shangri-La Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> d. STREET ADDRESS <u>8403 Merryview Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Laura May Feither</u>			4. DATE OF DEATH Month Day Year <u>10 13 1967</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1899</u>		9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months <u>03</u> Days <u>1</u> IF UNDER 24 HRS. Hours <u>03</u> Min <u>1</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto MD</u>			
13. FATHER'S NAME <u>Clayton Samuel</u> <u>John Hancock</u>			14. MOTHER'S MAIDEN NAME <u>Emma Harrison</u> <u>Mary E. Hancock</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-18-1571</u>		17. INFORMANT <u>Jos. Chart</u> Address <u></u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO <u></u> (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>30 yrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11/15</u>, 19<u>66</u>, to <u>10/13</u>, 19<u>67</u>, that <u>we</u> last saw the deceased alive on <u>10/13</u>, 19<u>67</u>, and that death occurred at <u>11:00 AM</u>, from causes on and on the date stated above.							
22a. SIGNATURE <u>David E. Zickfoose</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/13/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>DAVID E. ZICKFOOSE</u>			22d. ADDRESS <u>9 VFW Lane, Ellicott City, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>			
23d. LOCATION (City or Town) <u>Woodlawn</u>		(County) <u>Balto</u>		(State) <u>MD</u>			
24. FUNERAL DIRECTOR <u>Foring Byers</u> <u>8728 Liberty Rd</u>			25a. REC'D BY REGISTRAR <u>OCT 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13455						13461					
1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>216 WAMPLER RD.</u>						d. STREET ADDRESS <u>216 WAMPLER RD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA M. GERLACH</u>						4. DATE OF DEATH Month Day Year <u>OCT. 23 1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR. 5, 1889</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>ROTTMUND</u>						14. MOTHER'S MAIDEN NAME <u>?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MILTON GERLACH</u>			Address <u>216 WAMPLER</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>1957</u> , to <u>10-23</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>10-22</u> , 19 <u>67</u> , and that death occurred at <u>10⁰⁰</u> A.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>J.B. Littleton M.D.</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-23-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>J.B. LITTLETON M.D.</u>						22d. ADDRESS <u>1012 OLD NORTH PT. RD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT. 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOLLY HILL</u>			23d. LOCATION (City, town or county) (State) <u>BALTO. MD.</u>				
24. FUNERAL DIRECTOR <u>J.G. CONNELLY SONS</u>						ADDRESS <u>300 MACE</u>		25a. REC'D BY REGISTRAR <u>OCT 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1961

2815

DEPARTMENT OF DEFENSE

1961

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13457

CERTIFICATE OF DEATH

13457

1. PLACE OF DEATH a. COUNTY <u>Towson</u> <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>Freeland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph Hospital</u>		d. STREET ADDRESS <u>Gore Mill Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>W.</u> Last <u>Gilligan</u>		4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3/21/1900</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Station Attended</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Gilligan</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Weber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-20-3555</u>	
17. INFORMANT <u>Mrs. Margaret Ward</u>		Address <u>Freeland, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>coronary thrombosis</u> DUE TO (c) <u> </u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>10/18</u> , 19 <u>67</u> , to <u>10/22</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <u>10/22</u> , 19 <u>67</u> , and that death occurred at <u>6:10 p</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>W. Gilligan</u>		22b. DATE SIGNED <u>11/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thos Gilliani, M.D.</u>		22d. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/25/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Falls Road Chapel</u>	23d. LOCATION (City or Town) (County) (State) <u>Butler, Md.</u>
24. FUNERAL DIRECTOR <u>J. F. Eline & Sons Reisterstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SECRET

OFFICE OF THE SECRETARY OF DEFENSE

100-100000

MEMORANDUM

FOR THE SECRETARY

SUBJECT

DATE

1. SUMMARY

2. DISCUSSION

3. CONCLUSIONS

4. RECOMMENDATIONS

5. ACTION

6. COMMENTS

7. REFERENCES

8. ATTACHMENTS

9. DISTRIBUTION

10. ACTION

11. COMMENTS

12. ACTION

13. COMMENTS

14. ACTION

15. COMMENTS

16. ACTION

17. COMMENTS

18. ACTION

19. COMMENTS

20. ACTION

21. COMMENTS

22. ACTION

23. COMMENTS

24. ACTION

25. COMMENTS

26. ACTION

27. COMMENTS

28. ACTION

29. COMMENTS

30. ACTION

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13458

CERTIFICATE OF DEATH

13463

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 308 Ingleside Ave.				d. STREET ADDRESS 308 Ingleside Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nellie Agnes Gladmon				4. DATE OF DEATH Oct. 2		19 67	
5. SEX F	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/70		9. AGE (In years last birthday) 96 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wash., D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME --- Hawkshaw				14. MOTHER'S MAIDEN NAME ---			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Temple L. Gladmon 4516 Old Frederick Rd. - 21229			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary occlusion DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/22 , 19 65 , to 10/2 , 19 67 that (I) (we) last saw the deceased alive on 10/2 , 19 67 , and that death occurred at 19 M, from causes and on the date stated above.							
22a. SIGNATURE Robert A. Reiter				22b. DATE SIGNED 10/2/67		22c. PHYSICIAN'S NAME (Type) Robert A. Reiter, M. D.	
22d. ADDRESS 606 Edmondson Ave. - 21228				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/5/67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.				25a. REC'D BY REGISTRAR OCT 4 1967		25b. REGISTRAR'S SIGNATURE Johnas J. J...	

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REPORT OF

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
13459									
13464									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			c. LENGTH OF STAY IN 1b 13 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 21222				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 62 Willow Spring Road					d. STREET ADDRESS 62 Willow Spring Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK MUNROE GONGLOFF					4. DATE OF DEATH October 9th 1967				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/4/1921		9. AGE (In years last birthday) 46 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender				10b. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Milton O. Gongloff					14. MOTHER'S MAIDEN NAME Lilly F. Jenkins				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no					16. SOCIAL SECURITY NO. 176-16-0300		17. INFORMANT Helen R. Gongloff, same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Asphyxiation					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE M. B. Davis					22. DATE SIGNED 10/10/67				
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dundalk, Maryland Address (Street, city, town or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/13/67		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION (City, town or county) (State) A. A. Co., Md			
24. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk, Md.						25a. REC'D BY REGISTRAR OCT 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13465

13460

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 of this certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 46 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 825 N. CAROLINE STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First OTIS Middle PERNEL Last GOODWIN				4. DATE OF DEATH Month OCTOBER Day 31 Year 1967			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8/1/94	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY STEEL MILL		11. BIRTHPLACE (County & State, or foreign country) CLOVER, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM GOODWIN				14. MOTHER'S MAIDEN NAME ADA CONNER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 213 07 56 13		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF COLON WITH METASTASIS TO LIVER, 1538 DUE TO SKIN AND RECTUM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/15/67 , 19__, to 10/31/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/31/67 19__, and that death occurred at 12:45 AM from causes and on the date stated above.							
22a. SIGNATURE <i>Ahmed C. K. Kutty</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/31/67	
22c. PHYSICIAN'S NAME (Type) AHMED C. K. KUTTY, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/3/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>B. Lock</i> Lock Funeral Home				25a. REC'D BY REGISTRAR DATE NOV 1 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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Handwritten signature: James C. Kelly

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13461

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13466

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1437 Galena Road				d. STREET ADDRESS 1437 Galena Road			
3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN V. GOUKER				4. DATE OF DEATH Month Day Year October 11, 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1901	9. AGE (In years last birthday) 66 yrs.	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick O'Connor				14. MOTHER'S MAIDEN NAME Mary			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address George Gouker Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACVD DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Theodore C. Patterson		M.D. Theodore C. Patterson, M.D. 105 Main St. Dundalk, Md. 21222		22. DATE SIGNED 10/13/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/14/67	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md.		
24. FUNERAL DIRECTOR Brazdzinski Funeral Home 1407 Eastern Ave.				25a. REC'D BY REGISTRAR DATE OCT 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 23c per telephone conversation with hospital

CERTIFICATE OF DEATH

16527

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 30-y d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 21213 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3727 Elmley Ave. d. STREET ADDRESS 3727 Elmley Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Kathryn First Middle Last Graleski			4. DATE OF DEATH Month Day Year October 25, 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 25, 1967	9. AGE (In years lost birthday) yrs. 7	IF UNDER 1 YEAR Months Days Hours Min. 7 44
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Ronald Adam Graleski			14. MOTHER'S MAIDEN NAME Joanne Alice Bowers		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7593 IMMEDIATE CAUSE (a) Multiple congenital anomalies DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/25/ , 19 67 , to 10/25/ , 19 67 that 10 (we) last saw the deceased alive on 10/25/ , 19 67 , and that death occurred at 5:25PM , from causes and on the date stated above.					
22a. SIGNATURE Laurence Misanik M.D.			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Laurence Misanik M.D.			22d. ADDRESS 7620 York Rd., Towson, Md., 21204		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY U. of M. Anatomy Board		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR ADDRESS			25a. REC'D BY REGISTRAR DATE DEC 13 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN c. LENGTH OF STAY IN 1b 1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) BALTIMORE County GENERAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pikesville d. STREET ADDRESS 2832 MARPAT RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ABRAHAM N. M. I. GREENBERG First Middle Last 4. DATE OF DEATH Oct 29 1967 Month Day Year						5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 3/15/1898 9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months 7 Days 14 IF UNDER 24 HRS. Hours 14 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber 10b. KIND OF BUSINESS OR INDUSTRY SHOP 11. BIRTH PLACE (County & State, or foreign country) RUSSIA 12. CITIZEN OF WHAT COUNTRY? U.S.A.						13. FATHER'S NAME MORRIS GREENBERG 14. MOTHER'S MAIDEN NAME MIRIAM					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. NO 17. INFORMANT MRS. ANNA GREENBERG, 2822 MARPAT RD. #21208 Address						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Cancer of the Lung. DUE TO Conditions, if any, which gave rise to immediate cause (b) 163X (e), stating the underlying cause last. DUE TO (c) 163X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardio Vascular Disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						21. I certify that (I) (this hospital) attended the deceased from 9-28-1967 to 10-29-1967 that (I) (the) last saw the deceased alive on 10-29-1967, and that death occurred at 12:00 M. from the causes and on the date stated above. 22a. SIGNATURE Rolando A. Madambz M.D. 22c. PHYSICIAN'S NAME (Type) DR. S. N. TOMPAROV 22b. DATE SIGNED 10-27-67 22d. ADDRESS 3000 Park Heights Ave					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10-31-67 23c. NAME OF CEMETERY OR CREMATORY MOSES MONTIFILORE WOODMOOR 23d. LOCATION (City, town or county) (State) HEBREW BALTIMORE, MARYLAND						24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS. INC., XXXX6010 REISTERSTOWN RD ADDRESS 25a. REC'D BY REGISTRAR NOV 6 1967 25b. REGISTRAR'S SIGNATURE Charles Judge					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G395 11/21/67 kk

13463

13468

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			c. LENGTH OF STAY IN IB Baltimore 21229		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home			d. STREET ADDRESS 4402 Dunland Rd. Apt. E		
3. NAME OF DECEASED (Type or print) Margaret E. Griffith			4. DATE OF DEATH October 21, 1967		
5. SEX Female	6. COLOR OR RACE cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1888	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Joseph Squires			14. MOTHER'S MAIDEN NAME Catherine Stumph		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Bellevvedere Towers 706 Mrs Richard Carter Sr. 1190 W Belvedere		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1967 IMMEDIATE CAUSE (a) Sarcoma of right femur DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) INTERVAL BETWEEN ONSET AND DEATH 1 year					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from October, 1966 to Oct 20, 1967 that (I) (we) last saw the deceased alive on Oct. 19, 1967 , and that death occurred at 5 P.M. from causes and on the date stated above.					
22a. SIGNATURE D. C. MacLaughlin			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) D. C. MacLaughlin			22d. ADDRESS 303 N Rolling Rd Catonsville 28 Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 23, 1967	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION (City or Town) (County) (State) Pikesville Md.		
24. FUNERAL DIRECTOR Witzke & Sons 4101 Edmondson Ave.			25a. REC'D BY REGISTRAR OCT 25 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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13469

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 51 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 111 Hanover Road			d. STREET ADDRESS 111 Hanover Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HARMON Middle OLIN Last GRIMES			4. DATE OF DEATH Month October Day 17 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1887		9. AGE (In years last birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Balto. Gas & Elec.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Lewis A. Grimes			14. MOTHER'S MAIDEN NAME Marian Marsh		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-65-3312		17. INFORMANT Mrs. Lydia Grimes Address 111 Hanover Rd. Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5271 IMMEDIATE CAUSE (a) Pulmonary emphysema DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 18 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. none 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-1-41 , 19____ to 10-17-67 , 19____, that (I) (we) last saw the deceased alive on Oct. 13 , 19 67 , and that death occurred at 10:30 P M, from causes and on the date stated above.					
22a. SIGNATURE D. D. Caples			22b. DATE SIGNED 10-19-67		
22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.			22d. ADDRESS 6 Hanover Rd., Reisterstown, Md. 21136		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 20, 1967	23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Boring, Maryland	
24. FUNERAL DIRECTOR H. J. Schhardt			25a. REC'D BY REGISTRAR Owings Mills, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge

1251

STATE OF ILLINOIS

IN SENATE,
January 10, 1901.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE,
MAY 15, 1899.
CHAS. H. HARRIS,
COMMISSIONER.
ALBANY, N. Y.:
J. B. LIPPINCOTT & CO.,
PRINTERS.
1901.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13465

CERTIFICATE OF DEATH

13470

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. LENGTH OF STAY IN 1b <u>1 DAY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE COUNTY GENERAL</u>		d. STREET ADDRESS <u>3712 BUCKINGHAM RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>A</u> Last <u>GROSS</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/25/03</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERVISOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO. MD</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christian Gross</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-05-4054</u>	
17. INFORMANT <u>Estelle E Gross - Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>✓ Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> to <u>10/25, 1967</u> , that (I) (we) lost saw the deceased alive on <u>10/25, 1967</u> , and that death occurred at <u>10:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-28-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Memorial Gardens - Balto. Md</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Ellsworth Armocost - 4604 Liberty Heights Ave</u>		25a. REC'D BY REGISTRAR <u>OCT 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S NAME	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13-11-11

13-11-11

13-11-11

Form with multiple sections and fields, mostly illegible due to fading. Visible text includes:

- Top header: 13-11-11
- Section 1: [Illegible text]
- Section 2: [Illegible text]
- Section 3: [Illegible text]
- Section 4: [Illegible text]
- Section 5: [Illegible text]
- Section 6: [Illegible text]
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- Section 100: [Illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> c. LENGTH OF STAY IN 1b <i>46 days</i>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore md.</i> d. STREET ADDRESS <i>1916 Park Place</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>Alice</i> Last <i>Haddaway</i> 5. SEX <i>Female</i> 6. COLOR OR RACE <i>Cauc.</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>						4. DATE OF DEATH Month <i>October</i> Day <i>23</i> Year <i>1967</i> 9. AGE (In years last birthday) <i>79</i> yrs. IF UNDER 1 YEAR Months <i>7</i> Days <i>19</i> Hours <i>67</i> Min. IF UNDER 24 HRS. <i>79</i> yrs. 11. BIRTHPLACE (County & State, or foreign country) <i>Frederick City, Md.</i> 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>William Scott Reightler</i> 14. MOTHER'S MAIDEN NAME <i>Martin</i>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> 16. SOCIAL SECURITY NO. <i>213-03-4280</i> 17. INFORMANT <i>Martin</i> Address <i>1916 Park Place</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic well differentiated</i> 1750 DUE TO <i>adeno Carcinoma - Prominent schorrhous</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Selectr indicating Primary ovarian</i> DUE TO <i>Carcinoma</i> (c) <i>Carcinoma</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Intestinal obstruction 20 to 40</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No</i>											
20c. TIME OF INJURY Month, Day, Year <i>9/07</i> , 19 <i>67</i> Hour a.m. <i>6</i> p.m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i> 20f. (City or town) (County) (State) <i>Baltimore md.</i>											
21. I certify that (I) (this hospital) attended the deceased from <i>9/07</i>, 19 <i>67</i>, to <i>10/23</i>, 19 <i>67</i>, that (I) (we) last saw the deceased alive on <i>10/23</i>, 19 <i>67</i>, and that death occurred at <i>7:55</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Acquinone</i> 22b. DATE SIGNED <i>10/23/67</i> 22c. PHYSICIAN'S NAME (Type) <i>Acquinone</i> 22d. ADDRESS <i>M.D.</i> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> 23b. DATE THEREOF <i>10/26/1967</i> 23c. NAME OF CEMETERY OR CREMATORY <i>LORRRAINE PARK</i> 23d. LOCATION (City, town or county) (State) <i>BALTIMORE MD.</i>											
24. FUNERAL DIRECTOR <i>WITZKE & SONS</i> ADDRESS <i>4101 EDMONDSON AVE.</i> 25a. REC'D BY REGISTRAR <i>Oct 25 1967</i> 25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13467					13472				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Greater Baltimore Medical Center</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>			d. STREET ADDRESS <u>3001 Pulaski Hgway.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY ALBERT HALE Sr.</u>		4. DATE OF DEATH Month Day Year <u>Oct. 7 1967</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>10-14-10</u>		9. AGE (In years last birthday) <u>56</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hale Trailer Park</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James Hale</u>				14. MOTHER'S MAIDEN NAME <u>JACKSON, Edna</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-05-4036</u>		17. INFORMANT <u>Harry A. Hale Jr.</u>		Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular failure</u> <u>150x</u> DUE TO (b) <u>CA of esophagus</u> DUE TO (c) <u>esophageal rupture</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9-15</u> , 19 <u>67</u> , to <u>10-7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-7</u> 19 <u>67</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Rahim Bassiri</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>DR. RAHIM BASSIRI</u>				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/11/67</u>		23c. NAME OF CEMETERY OR CREMATORY. <u>Gardens of Faith Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Md</u>			
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>				25a. RECEIVED BY REGISTRAR <u>OCT 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			c. LENGTH OF STAY in lb 2 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital					d. STREET ADDRESS 39 Hanover Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Lionel Last HAMPTON					4. DATE OF DEATH Month 10 Day 13 Year 1967				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-2-57		9. AGE (In years last birthday) 10 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Harford, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Tilghman Hill					14. MOTHER'S MAIDEN NAME Eleanor Bond				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Address Rosewood Records, Owings Mills, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Orthostatic bronchial Pneumonia 1939 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Astrocytoma Grade I-II DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 months									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/8 , 19 67 , to 10/13 , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/13 , 19 67 , and that death occurred at 3:05a m, from causes and on the date stated above.									
22a. SIGNATURE Richard A. Jones					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-13-67		
22c. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.					22d. ADDRESS Rosewood State Hosp., Owings Mills, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 18, 1967		23c. NAME OF CEMETERY OR CREMATORY St. James A.M.E. Cemetery			23d. LOCATION (City or Town) (County) (State) Harford, Md.		
24. FUNERAL DIRECTOR Elmer E. Bullock					25a. REC'D BY REGISTRAR Harford, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge		

1964

STATEMENT OF WORK

Project

Location

Period

Personnel

1964

1965

1966

1967

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Longwood Drive</u>		d. STREET ADDRESS <u>33 Longwood Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Noah Patterson Hamrick</u>			
4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/14/00</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Clay County W. VA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Henry Hamrick</u>	
14. MOTHER'S MAIDEN NAME <u>Young</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>213-01-3448</u>		17. INFORMANT <u>Patient Chart</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> DUE TO <u>Obstetric, pulmonary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from <u>Sept. 3</u> , 19 <u>67</u> , to <u>Oct. 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>October 4</u> , 19 <u>67</u> , and that death occurred at <u>2:00</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Anastacia E. Fabie</u>		22b. DATE SIGNED <u>Oct. 4, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Anastacia E. Fabie</u>		22d. ADDRESS <u>GREATER BALTIMORE MED. CENTER</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/7/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HOLLY HILL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD.</u>
24. FUNERAL DIRECTOR <u>Connolly J.H.</u>		25a. REC'D BY REGISTRAR <u>300 Mac</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>OCT 9 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 02-08-2001 BY 60322 UCBAW/SJS

[illegible]

13430

CERTIFICATE OF DEATH

13475

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>20 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1 E. University Pkwy</u> d. STREET ADDRESS <u>Balto. MD. Zone 18</u>	
3. NAME OF DECEASED (Type or print) <u>Marie</u> First <u>L.</u> Middle <u>Hardwell</u> Last <u>Hardwell</u>		4. DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-23-1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (County & State, or foreign country) <u>BALTO. MD.</u>
13. FATHER'S NAME <u>Millard Leonard</u>		14. MOTHER'S MAIDEN NAME <u>SOUTHCOMB Mary L. Leonard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>057-1005870</u>	
17. INFORMANT <u>Admission Sheet</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170x</u> DUE TO <u>CANCER OF BREAST TO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>METASTASIS TO THE LUNGS</u> (b) <u>CANCER OF BREAST TO</u> DUE TO <u>METASTASIS TO THE LUNGS</u> (c) <u>METASTASIS TO THE LUNGS</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-13</u> , 19 <u>67</u> , to <u>10-2</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10-2</u> , 19 <u>67</u> , and that death occurred at <u>6:57 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Jose M. de Leon, M.D.</u>		22b. DATE SIGNED <u>10-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSE M. DE LEON, M.D.</u>		22d. ADDRESS <u>Greater Balto. Medical Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/4/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>		25a. REC'D BY REGISTRAR <u>OCT 3 1967</u>	
ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



[Faint handwritten notes at the bottom of the page, possibly bleed-through from the reverse side.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13471 CERTIFICATE OF DEATH 13476									
1. PLACE OF DEATH a. CDUNTY <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>Towson</u>			c. LENGTH OF STAY IN 1b <u>1 Day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> <u>21204</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>					d. STREET ADDRESS <u>615 Chestnut Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LUCY</u>		First <u>LUCY</u>		Middle <u>LEE</u>		Last <u>HARVEY</u>		4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>19 67</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 24, 1884</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse R/N</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Edward Harvey</u>					14. MOTHER'S MAIDEN NAME <u>Ann Virginia Dwyer</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-03-5015</u>		17. INFORMANT <u>Pickersgill Home, same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrolyte imbalance</u> <u>5703</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal obstruction</u> DUE TO (c) <u>Volvulus of cecum with adhesions</u>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic Cardiovascular Disease</u>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 11</u> , 19 <u>67</u> , to <u>Oct. 12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct. 12</u> , 19 <u>67</u> , and that death occurred at <u>2:45M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>John E. Adams</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> PM MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>10/13/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>John E. Adams, M.D.</u>					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Oct. 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Patuxent Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sunshine, Maryland</u>			
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, 1050 York Road</u>					25a. REC'D BY REGISTRAR <u>OCT 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>William Cook-Brooks</u>		
					Towson, Maryland 21204				

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 12 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle -- Last HASTE, JR.		4. DATE OF DEATH Month OCTOBER Day 18 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/8/17
9. AGE (In years last birthday) yrs. 50		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER		10b. KIND OF BUSINESS OR INDUSTRY NAVAL ACADEMY	
11. BIRTHPLACE (County & State, or foreign country) ANNAPOLIS, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE HASTE		14. MOTHER'S MAIDEN NAME ANNIE CREEK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 214 05 17 11	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538 DUE TO INTESTINAL OBSTRUCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF LARGE BOWEL WITH METASTASIS TO LIVER DUE TO UNKNOWN (c)		INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 10/6/67 , to 10/18/67 , that we last saw the deceased alive on 10/18/67 , and that death occurred at 4:15 PM from causes and on the date stated above.			
22a. SIGNATURE George C. McElpatrick, M.D.		22b. DATE SIGNED 10/19/67	
22c. PHYSICIAN'S NAME (Type) GEORGE C. McELPATRICK, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-23-67	23c. NAME OF CEMETERY OR CREMATORY Brewer Hill	23d. LOCATION (City or Town) (County) (State) Annapolis MD
24. FUNERAL DIRECTOR William Reese Jr.		25a. DATE OF REGISTRATION OCT. 20 1967	
25b. REGISTRAR'S SIGNATURE James J. [Signature]		25c. REGISTRAR'S NAME REESE FUNERAL HOME ANNAPOLIS, MARYLAND	

NAME: GEORGE W. HASTE
RANK: MAJ
BRANCH: NAVAL ACADEMY
DATE: 10/11/54
PLACE: ANNAPOLIS, MARYLAND
U.S.A.
REMARKS: INTERVIEWED ON 10/11/54 AT ANNAPOLIS, MARYLAND. HE IS A RESIDENT OF ANNAPOLIS, MARYLAND. HE IS A MAJOR IN THE NAVAL ACADEMY. HE IS A MAJOR IN THE NAVAL ACADEMY. HE IS A MAJOR IN THE NAVAL ACADEMY.

DATE: 10/11/54
PLACE: ANNAPOLIS, MARYLAND
U.S.A.
REMARKS: INTERVIEWED ON 10/11/54 AT ANNAPOLIS, MARYLAND. HE IS A RESIDENT OF ANNAPOLIS, MARYLAND. HE IS A MAJOR IN THE NAVAL ACADEMY. HE IS A MAJOR IN THE NAVAL ACADEMY. HE IS A MAJOR IN THE NAVAL ACADEMY.

13473

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13478

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Pikesville		c. LENGTH OF STAY IN 1b 12 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Foxleigh Nursing Home		e. STREET ADDRESS 5726 Uffington Rd. 21209	
3. NAME OF DECEASED (Type or print) First Annie Middle O Last Hearn		4. DATE OF DEATH Month Oct. Day 30 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13 1877
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas Orem		14. MOTHER'S MAIDEN NAME Virginia Frazier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-54-2671 JI	
17. INFORMANT Miss Mildred Hearn		Address 5726 Uffington Rd Balto. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Pneumonia due to Hemorrhage during surgery for repair of injury of April 13 of 1967 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4 weeks. (c) C.V. & other diseases		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in home and struck his femur on fireplace	
20c. TIME OF INJURY Month, Day, Year Hour 7:35 a.m. 9/19 1967 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) BALTIMORE MARYLAND	
21. I certify that (I) (this hospital) attended the deceased from 1/16, 1967 to 10/29, 1967 , that (I) (we) last saw the deceased alive on 10/29 1967 , and that death occurred at 7:34 M, from causes and on the date stated above.			
22a. SIGNATURE Jeanette R. Heghinian		22b. DATE SIGNED 10/31/67	
22c. PHYSICIAN'S NAME (Type) Dr. Jeanette R. Heghinian		22d. ADDRESS 2212 South Road Balto. Md.	
23a. BURIAL, CREMATION, REINTERMENT Burial		23b. DATE THEREOF 11/2/67	
23c. NAME OF CEMETERY OR CREMATORY Cambridge		23d. LOCATION (City or Town) (County) (State) Cambridge Md.	
24. FUNERAL DIRECTOR Spring Myers		25a. REC'D BY REGISTRAR NOV 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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LABORATORY OF

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13479

13474

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with forms PM-8. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>		d. STREET ADDRESS <u>3014 Linwood Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>M.</u> Last <u>Heill</u>		4. DATE OF DEATH Month <u>10</u> / Day <u>28</u> / Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 7, 1905</u> 62 yrs.
9. AGE (In years last birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>220-18-2694</u>		17. INFORMANT <u>Henry P. Heill Jr.</u> Address <u>Timonium, Md. 31 Evans Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Occlusion Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	
20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-3-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>		25c. DATE SIGNED <u>10/28/67</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13475

13480

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2422 Rolling Road				e. STREET ADDRESS 2422 Rolling Road			
3. NAME OF DECEASED (Type or print) Rowena E. Hemmings				4. DATE OF DEATH Month October Day 13 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH April 20, 1885	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Tazewell Co., Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Yost				14. MOTHER'S MARDEN NAME Harriet Moore			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Frieda Beimschla Address Balto. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infection DUE TO (b) Cerebral of stomach with metastases DUE TO (c) Chronic of stomach with metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 9, 1967 , to October 13, 1967 , that (I) (we) last saw the deceased alive on October 12, 1967 , and that death occurred at 2:25 P.M. from causes and on the date stated above.							
22a. SIGNATURE Edwin L. Pierpont				22b. DATE SIGNED 10/13/67			
22c. PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D.				22d. ADDRESS 8204 LIBERTY RD - Balto 21207 Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/15/67	23c. NAME OF CEMETERY OR CREMATORY Hankins Cemetery		23d. LOCATION (City or Town) (County) (State) Richlands Tazewell Va.			
24. FUNERAL DIRECTOR Foring Byers Randallston Ind				25a. REC'D BY REGISTRAR OCT 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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STATEMENT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13476

CERTIFICATE OF DEATH

13481

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 304		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 21218	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			d. STREET ADDRESS 1731 Chilton St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Franklin W Henderson			4. DATE OF DEATH Month Day Year October 20, 1967		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1885		9. AGE (In years last birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Owner		10b. KIND OF BUSINESS OR INDUSTRY Plumbing & Heating		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME George W. Henderson			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-6184		17. INFORMANT Address Mrs. Eva I. Henderson Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure and Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Uremia DUE TO (c) Arterioscler Nephrosclerosis, Basilar Artery Thrombosis					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 17 , 19 67 , to Oct. 20 , 19 67 that (I) (we) last saw the deceased alive on Oct. 20 19 67 , and that death occurred at 11:55 PM from causes and on the date stated above.					
22a. SIGNATURE <i>Beatriz P. Dizon</i>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-20-67
22c. PHYSICIAN'S NAME (Type) Beatriz P. Dizon			22d. ADDRESS 7620 York Rd., Towson-21204, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-24-67		23c. NAME OF CEMETERY OR CREMATORY Woodlawn	
23d. LOCATION (City or Town)		(County)		(State)	
Balto, Md.		Balto, Md.		Balto, Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.			25a. REC'D BY REGISTRAR OCT 23 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

11-11

RECEIVED IN DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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13477

CERTIFICATE OF DEATH

13482

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>30-4</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Nursing Home</u>		d. STREET ADDRESS <u>2725 Maryland Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>E.</u> Last <u>Herbert</u>		4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1909</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 Year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Ormond</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>William B Herbert</u>		Address <u>Wash. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cerebrovascular disease.</u> DUE TO <u>334X</u> (b) <u>2 yrs +</u> DUE TO <u>INTERVAL BETWEEN ONSET AND DEATH</u> (c) <u>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>1964</u> , 19 <u>64</u> , to <u>OCT 27</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>OCT 27</u> 19 <u>67</u> , and that death occurred at <u>11</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>John A Nesbitt Jr</u>		22b. DATE SIGNED <u>10-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John A Nesbitt Jr</u>		22d. ADDRESS <u>1009 Frederick Rd Balt. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/31/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>OCT 31 1967</u>	

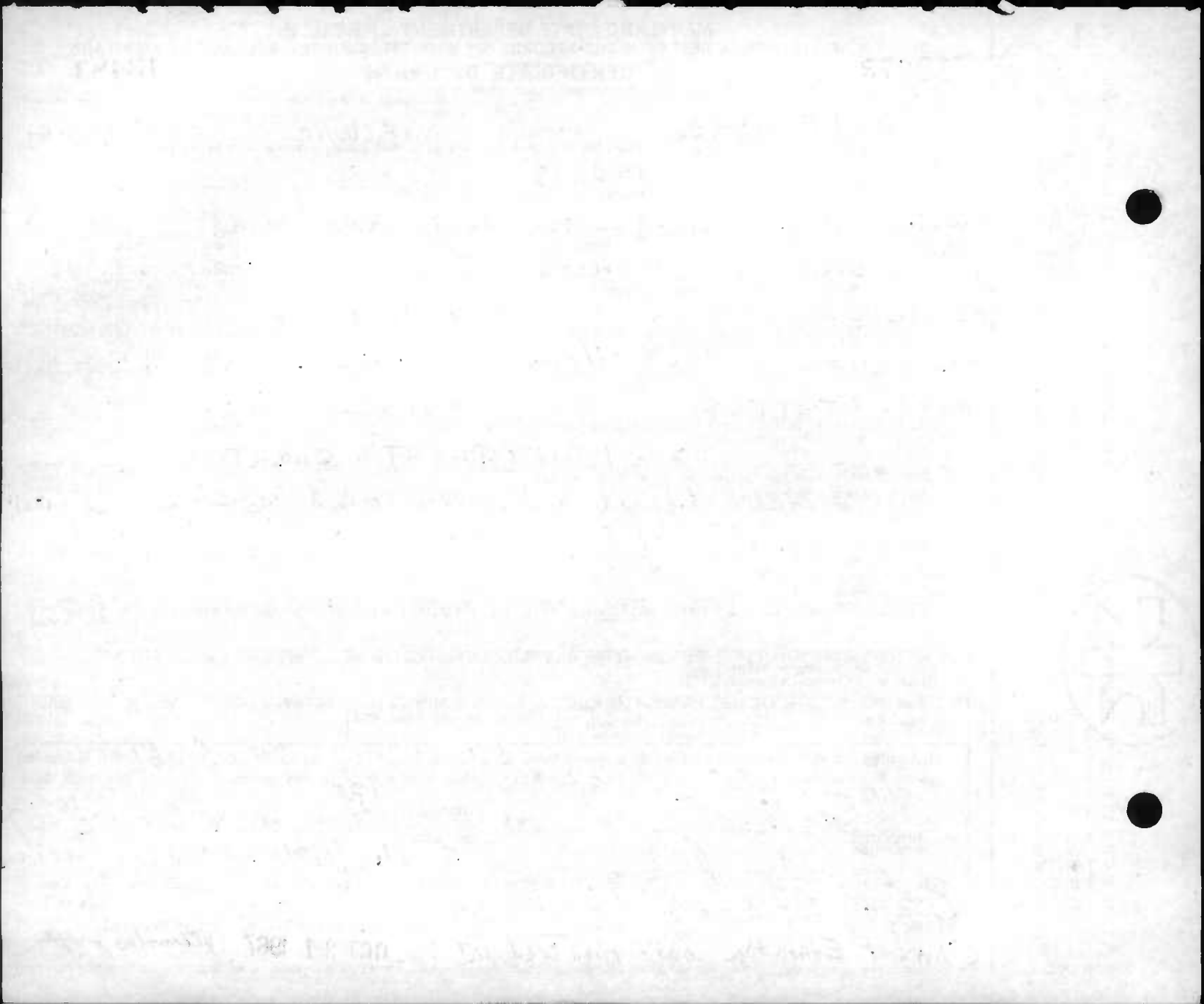
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13478					13483				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 18 DAYS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CARNEY				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER					d. STREET ADDRESS 2607 HIRWOOD ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) DORIS			First Middle Last ELIZABETH HESS		4. DATE OF DEATH OCTOBER 28, 1967 Month Day Year				
5. SEX Female	6. COLOR OR RACE cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 15, 1924		9. AGE (in years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME HARRY STETTES					14. MOTHER'S MAIDEN NAME MEISZ, Helen				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 215-14-5098		17. INFORMANT PATIENT'S CHART Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) diffuse and wide spread metastasis of cervical carcinoma 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from OCT 11, 1967 , to OCT 28, 1967 , that (I) (we) last saw the deceased alive on OCT 28, 1967 , and that death occurred at 9:30 PM , from the causes and on the date stated above.									
22a. SIGNATURE [Signature]					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED OCT 28 67		
22c. PHYSICIAN'S NAME (Type) Greater Baltimore Medical Center					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 11-2-67		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD		23d. LOCATION (City, town or county) (State) BALTO MD		
24. FUNERAL DIRECTOR CHAS F. EVANS					ADDRESS 8802 HARTFORD RD		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE [Signature] DATE OCT 31 1967		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13484

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium			c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium 03.1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 400 Chapel Wood Lane				d. STREET ADDRESS 400 Chapel Wood Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Florence Middle Darcy Last Higgins				4. DATE OF DEATH Month October Day 8 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 10, 1891	
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (County & State, or foreign country) New York				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Barnett				14. MOTHER'S MAIDEN NAME Katherine Buggy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. No		17. INFORMANT Address Mrs. Florence Paul 400 Chapel Wood Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BREAST 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 22, 1967 , to Oct 8, 1967 , that (I) (we) lost the deceased on Oct. 8, 1967 , and that death occurred at 10A M, from causes and on the date stated above.							
22a. SIGNATURE William A. Pillsbury				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-9-67	
22c. PHYSICIAN'S NAME (Type) William A. Pillsbury				22d. ADDRESS Timonium, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/10/67		23c. NAME OF CEMETERY OR CREMATORY St. Joseph Texas Cemetery		23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204				25a. REC'D BY REGISTRAR OCT 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MINUTE OF MEETING

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13485

13480

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box #477 Kingsville, Md. Sunshine Ave.		d. STREET ADDRESS Box # 477 Kingsville, Md.	
3. NAME OF DECEASED (Type or print) Evelynn Mary Higgs.		4. DATE OF DEATH Month October Day 27 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/11/1924
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 53
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Karl A. Gabler.		14. MOTHER'S MAIDEN NAME Mary Huber.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Kenneth E. Higgs Sunshine Ave. Box #477		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF UTERUS DUE TO (b) Wide-spread metastases DUE TO (c) Ch. Cholelithiasis; Ch. Pancreatitis; Alcoholism		INTERVAL BETWEEN ONSET AND DEATH 20 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH-BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/14 19 66 , to 10/27 19 67 , that (I) (we) last saw the deceased alive on 10/27 19 67 , and that death occurred at 4:40 PM , from causes and on the date stated above.			
22a. SIGNATURE Clifford F. Hudson		22b. DATE SIGNED 10/27/67	
22c. PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON		22d. ADDRESS FORK, MD. 21051	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial.		23b. DATE THEREOF 10/30/67	
23c. NAME OF CEMETERY OR CREMATORY Belair Memorial		23d. LOCATION (City or Town) (County) (State) Belair, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, inc. 5305 Harford Rd.		25a. REC'D BY REGISTRAR DATE OCT 31 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

1955

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

STATEMENT OF WITNESS

Witness: Mr. [Name], [Address], [City], [State], [Zip]

Witness: Mr. [Name], [Address], [City], [State], [Zip]

Witness: Mr. [Name], [Address], [City], [State], [Zip]

Witness: Mr. [Name], [Address], [City], [State], [Zip]

Witness: Mr. [Name], [Address], [City], [State], [Zip]

Witness: Mr. [Name], [Address], [City], [State], [Zip]

Witness: Mr. [Name], [Address], [City], [State], [Zip]

Witness: Mr. [Name], [Address], [City], [State], [Zip]

Witness: Mr. [Name], [Address], [City], [State], [Zip]

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Witness: Mr. [Name], [Address], [City], [State], [Zip]

Witness: Mr. [Name], [Address], [City], [State], [Zip]

Witness: Mr. [Name], [Address], [City], [State], [Zip]

Witness: Mr. [Name], [Address], [City], [State], [Zip]

Witness: Mr. [Name], [Address], [City], [State], [Zip]

Witness: Mr. [Name], [Address], [City], [State], [Zip]

Witness: Mr. [Name], [Address], [City], [State], [Zip]

Witness: Mr. [Name], [Address], [City], [State], [Zip]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SHIPPED TO: MORRIS FUNERAL HOME, CHERAW, SOUTH CAROLINA

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 31 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1325 LUZERNE AVENUE	
3. NAME OF DECEASED (Type or print) First JAMES Middle HILLIAN Last HILLIAN		4. DATE OF DEATH Month OCTOBER Day 11 Year 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/13
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL	
11. BIRTHPLACE (County & State, or foreign country) CHESTERFIELD, S. CAR.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RUFES HILLIAN		14. MOTHER'S MAIDEN NAME SARAH MURIMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 251 03 62 87	
17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, BILATERAL UNDETERMINED ORGANISM 16/8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SQUAMOUS CELL CARCINOMA, LARYNX DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH RECENT MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from SEPT 10, 1967 to OCT 11, 1967 , that he (we) last saw the deceased alive on OCT 11, 1967 , and that death occurred at 4:35 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 10/11/67	
22c. PHYSICIAN'S NAME (Type) KRISHNA V. S. RAO, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 10-14-67	
23c. NAME OF CEMETERY OR CREMATORY DRUCILLA CHURCH CEMETERY		23d. LOCATION (City or Town) (County) (State) CHESTERFIELD, SOUTH CAROLINA	
24. FUNERAL DIRECTOR MORTEN & DYETT FUNERAL HOME LAURENS STREET, BALTIMORE, MD.		25. REGISTRAR 3 1967	
26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		27. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

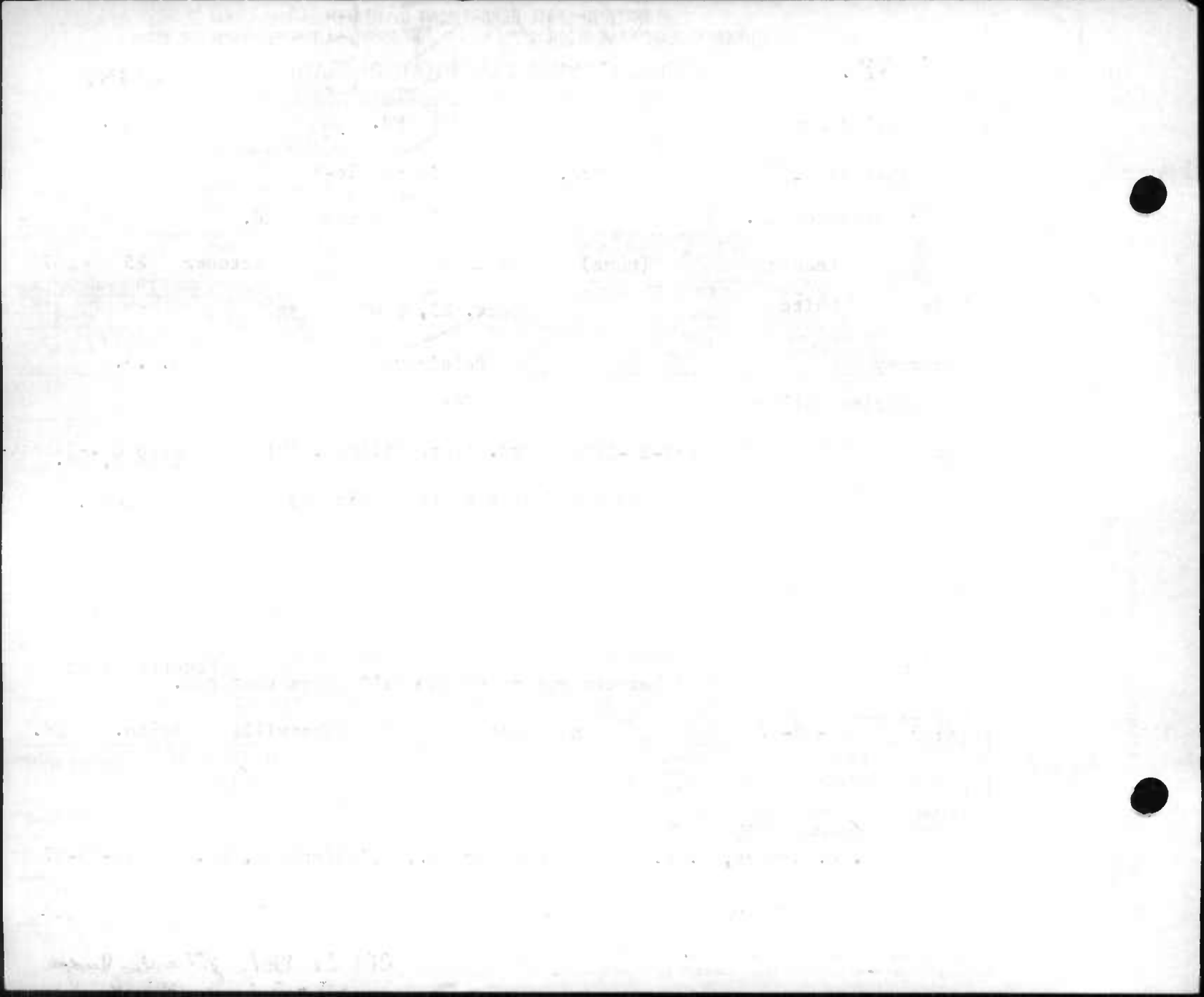
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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville-8		c. LENGTH OF STAY IN lb 9 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7915 Stevenson Rd.		e. STREET ADDRESS 7915 Stevenson Rd.	
3. NAME OF DECEASED (Type or print) Leonard First (none) Middle Hillman Last		4. DATE OF DEATH Month October Day 25 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1909
9. AGE (In years last birthday) yrs. 58		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Hillman		14. MOTHER'S MAIDEN NAME Ida	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217-38-3479	
17. INFORMANT Mrs. Flora Hillman, 7915 Stevenson Rd., Pikesville 8, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of the head (suicide) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 976x (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 2min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) self between eyebrows with 4:10 gauge shot gun.	
20c. TIME OF INJURY Month, Day, Year before 4:05 p.m. 10-25-67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Pikesville Balto. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples M.D.		22. DATE SIGNED 10-26-67	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		6 Hanover Rd., Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/27/67	23c. NAME OF CEMETERY OR CREMATORY Balto Hebrew	23d. LOCATION (City or Town) (County) (State) Balto Md
24. FUNERAL DIRECTOR Sylvan S. Lewis & Son, INC		25a. REC'D BY REGISTRAR DATE OCT 27 1967	
25b. REGISTRAR'S SIGNATURE Johnas Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE						c. LENGTH OF STAY IN 1b 77 years					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOUSE IN THE PINES NURSING HOME CATONSVILLE, MD.						d. STREET ADDRESS 1916 Old Frederick Rd					
3. NAME OF DECEASED (Type or print) First HENRY Middle C. Last HOFFMAN SR.						4. DATE OF DEATH Month Oct. Day 29 Year 19 67					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 9, 1890		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Poultryman				10b. KIND OF BUSINESS OR INDUSTRY Poultry		11. BIRTHPLACE (County & State, or foreign country) Catonville, Md.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Hoffman						14. MOTHER'S MAIDEN NAME Katherine Kaiser					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW I				16. SOCIAL SECURITY NO. 213-32-0437		17. INFORMANT Mrs Cecelia G. Hoffman Address 1916 Old Fred					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure 4221 DUE TO (b) ASCVD with severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) cerebral ischemia										INTERVAL BETWEEN ONSET AND DEATH 2 d. 2 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1/17, 1963 to 10/29, 1967 , that (I) (we) last saw the deceased alive on 10/29 1967 , and that death occurred at 3 PM , from the causes and on the date stated above.											
22a. SIGNATURE James E. Rowe						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/30/67			
22c. PHYSICIAN'S NAME (Type) JAMES E. ROWE						22d. ADDRESS CATONSVILLE MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Nov 2, 1967		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cent Baltimore Maryland			23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR STERLING FUNERAL ESTATE						ADDRESS 736 Edm. Ave. Catonsville, Md.		25a. REC'D BY REGISTRAR NOV 1 1967			
						25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13484

CERTIFICATE OF DEATH

13489

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b Jan. 9, 1961 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware b. COUNTY Delmar c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar d. STREET ADDRESS Jewel Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Allen Middle HOLDCRAFT Last Allen				4. DATE OF DEATH Month October Day 8 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 23, 1904	
9. AGE (In years lost birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME xxxxxx Mary Miller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 165-05-0258		17. INFORMANT Spring Grove Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure (immediate) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease, and aspiration due Vomiting DUE TO (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epileptic Seizures due to Intracerebral Injury Oct. 1960 (operated)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2" laceration in rt. temporal region on Oct. 2, 1967 (minor)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Body released by Dr. James Frederick Coroner		(State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 9, 1961 to Oct. 8, 1967 , that (I) (we) lost the deceased alive on Oct. 8, 1967 , and that death occurred at 4:45 P.M. , from causes and on the date stated above.							
22a. SIGNATURE James Kopits				22b. DATE SIGNED Oct. 8, 1967		22c. PHYSICIAN'S NAME (Type) Imre Kopits, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/13/67		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		23d. LOCATION (City or Town) (County) (State) Montgomery County, Pa.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. Baltimore, Md. 21202				25a. REC'D BY REGISTRAR OCT 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13485					13490						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Baltimore					a. STATE Maryland						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson					b. COUNTY Harford						
c. LENGTH OF STAY IN 1b 3 Years					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Havre de Grace						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Armacost Nursing Home					d. STREET ADDRESS 810 S. Union Ave.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH						
First Middle Last Maude Welsh Hollahan					Month Day Year October 28 1967						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 4, 1895		9. AGE (In years last birthday) 71 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME John T. Welsh					14. MOTHER'S MAIDEN NAME Jane McGee						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Margaret Fahey, 719 Chesapeake Dr.			Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 30 minutes 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from June , 19 66 , to 10-28 , 19 67 , that (I) (we) last saw the deceased alive on Aug 28 , 19 67 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE Franklin E. Leslie					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/30/67				
22c. PHYSICIAN'S NAME (Type) Franklin Leslie					22d. ADDRESS M. D. 302 E. 33rd St. Balto. Md. 21210						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Erin Cemetery			23d. LOCATION (City, town or county) (State) Havre de Grace, Md.				
24. FUNERAL DIRECTOR Pennington & Son, Havre de Grace, Md.					25a. REC'D BY REGISTRAR NOV 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge				

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13486				CERTIFICATE OF DEATH				13491			
Items #2e & d Film #6393 10/10/67											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u> Maryland </u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville Baltimore</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Melford Manor Nursing Home</u>						d. STREET ADDRESS <u>4204 Long Meadow Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eva</u> First Middle Last						4. DATE OF DEATH <u>Oct. 1</u> Month Day Year		19 <u>67</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-1-89</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York City</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Cohen</u>						14. MOTHER'S MAIDEN NAME <u>Ethel</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY # <u>050-18-3374</u>		17. INFORMANT <u>Morton J. Hollander</u>		Address <u>7941 Longmeadow Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.0</u> DUE TO <u>ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/31</u> , 19 <u>67</u> , to <u>10/1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/30</u> , 19 <u>67</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Joseph S. Blum</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/1/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM, MD</u>						22d. ADDRESS <u>1115 N. CALVERT ST</u>		<u>BALTO-MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>October 1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Freed</u>				23d. LOCATION (City, town or county) (State) <u>Brooklyn New York</u>			
24. FUNERAL DIRECTOR <u>Salvatore Bros. F.H.</u>						ADDRESS <u>6010 Reservoir Rd</u>		25a. REC'D BY REGISTRAR <u>Oct 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1911

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[Faint, mostly illegible handwriting on lined paper, possibly a ledger or notebook page. Some words like "Total" and "per" are visible.]

COPIES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #2c & d File #G393 10/23/67 ph

CERTIFICATE OF DEATH

13487

13492

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 21221</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mulany Towson Nursing Home 1111 West Road</u>		d. STREET ADDRESS <u>5911 Glenkirk Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth C. Hough</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (1879) AGE (In years lost birthday) <u>89</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>WALTER (Clement Jos. Meyer)</u>		14. MOTHER'S MAIDEN NAME <u>Meyers (Eliz. Deberding)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-46-0070</u>	
17. INFORMANT <u>Mrs. Edw. Buckler, Jr.</u>		Address <u>-609 Hampton Lane-04</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stokes-Adams syndrome with cardiac arrest</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>14 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/31</u> , 19 <u>64</u> , to <u>10/12</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10/1</u> , 19 <u>67</u> , and that death occurred at <u>9:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. F. Cox</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/16/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR <u>MITCHELL-WIEDEFELD HOME-6500 York Rd. 21212</u>		25a. REC'D BY REGISTRAR <u>OCT 18 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13488

CERTIFICATE OF DEATH

13493

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>				c. LENGTH OF STAY IN 1b <u>21223</u> <u>30-4</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baito. Co. Gen. Hosp</u>				d. STREET ADDRESS <u>1835 FAIRMONT AVE.</u>			
3. NAME OF DECEASED (Type or print) First <u>ETTA</u> Middle <u>M</u> Last <u>HOUSTON</u>				4. DATE OF DEATH Month <u>10</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-14</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.		IF UNDER 24 HRS. Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day worker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Tar</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-14-8743</u>		17. INFORMANT <u>Samuel Houston</u> Address <u>1835 Fairmount Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Cerebral Hemorrhage</u> DUE TO (b) <u>Severe Hypertension</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-20-1967</u> , to <u>10-21-1967</u> , that (I) (we) last saw the deceased alive on <u>10-20-1967</u> , and that death occurred at <u>2:35 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Cesar Valle Caverio</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERIO</u>				22d. ADDRESS <u>8629 Liberty Rd</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Westport (Baltimore) Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Russ</u>				25a. REC'D BY REGISTRAR <u>2222 St. North Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

13493

OFFICE OF THE

13493

Blank lined form with horizontal ruling lines.

TO THE DIRECTOR OF THE BUREAU OF REVENUE
WASHINGTON, D. C.
FROM THE COMMISSIONER OF THE BUREAU OF REVENUE
WASHINGTON, D. C.
SUBJECT: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13489

CERTIFICATE OF DEATH

13494

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7818 Oak Avenue			d. STREET ADDRESS 7818 Oak Avenue 21234		
3. NAME OF DECEASED (Type or print) Amanda Wilhelmina Hughes			4. DATE OF DEATH Month 10 Day 15 Year 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-20-1894		9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
13. FATHER'S NAME John Schuster			14. MOTHER'S MAIDEN NAME Charlotte Ball		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John Hughes Jr. 7818 Oak Avenue 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, Rt. Acute. DUE TO (b) Hypertensive Cardiovascular Disease stating the underlying cause last. (c) 443X					INTERVAL BETWEEN ONSET AND DEATH 6 hrs. ± 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NO INJURY			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 14 Oct 1967 , to 14 Oct 1967 , that (I) (we) last saw the deceased alive on 14 Oct 1967 , and that death occurred at 12:55 AM from causes on and on the date stated above.					
22a. SIGNATURE Edward L. J. Moiz			22b. DATE SIGNED 16 Oct 67		22c. PHYSICIAN'S NAME (Type) Edward L. J. Moiz, M.D.
22d. ADDRESS 7425 Harford Rd Balto. Md (34)			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-1967		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cemetery	
23d. LOCATION (City or Town) Baltimore		(County) Co		(State) Md	
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road			25a. REC'D BY REGISTRAR OCT 18 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge

13-101

20288

DEPARTMENT OF DEFENSE

RECEIVED AT THE OFFICE OF THE SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301

TO: THE SECRETARY OF DEFENSE

FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

CLASSIFICATION: [illegible]

CONTROL NUMBER: [illegible]

REPORT NUMBER: [illegible]

PROJECT NUMBER: [illegible]

1. SUMMARY

2. INTRODUCTION

3. BACKGROUND

4. OBJECTIVES

5. METHODS

6. RESULTS

7. DISCUSSION

8. CONCLUSIONS

9. REFERENCES

10. APPENDICES

11. GLOSSARY

12. INDEX

13. DISTRIBUTION STATEMENT

14. OTHER INFORMATION

NO [illegible]

13430

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13495

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY Balt			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GARRISON		c. LENGTH OF STAY IN 1b 1 yr 3 mo 24 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FOXLEIGH NURSING HOME				d. STREET ADDRESS 3219 McShane Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARL Middle NELSON Last HUNT				4. DATE OF DEATH Month 10 Day 26 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/28/89		9. AGE (In years last birthday) yrs. 83	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Hospital Worker		11. BIRTHPLACE (County & State, or foreign country) Minersville, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL HUNT				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Mrs Anna Hunt Address 3219 McShane Way, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Hours unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 7-3 , 19 66 , to 10-26 , 19 67 , that (1) (we) lost the deceased alive on 10-26 19 67 , and that death occurred at 5:30 PM , from causes on and on the date stated above.							
22a. SIGNATURE David J. Miller M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-26-67	
22c. PHYSICIAN'S NAME (Type) David J. Miller				22d. ADDRESS Clason Rd Owings Mills, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Oct. 30, 1967		23c. NAME OF CEMETERY OR CREMATORY George Washington Memorial Park, Baltimore		23d. LOCATION (City or Town) (County) (State) New Jersey	
24. FUNERAL DIRECTOR Frank A. Newell, Pikesville, Md.				25a. REC'D BY REGISTRAR DATE OCT 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1024

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Caltriders Lane		d. STREET ADDRESS Caltriders Lane	
3. NAME OF DECEASED (Type or print) First ERVIN Middle REXFORD Last JACOBS		4. DATE OF DEATH Month October Day 11 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 27 1937
9. AGE (In years lost birthday) 30 yrs.		10. IF UNDER 1 YEAR Months 30 Days 30 Hours 30 Min. 30	
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) DRY WALL HANGER		10b. KIND OF BUSINESS OR INDUSTRY BACK W. BROAD HURST	
11. BIRTHPLACE (State or foreign country) CLINTON NC		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STEPHEN JACOBS		14. MOTHER'S MAIDEN NAME MARY AMMONS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If in, give date of discharge) YES 54 TC 58		16. SOCIAL SECURITY NO. 54 TC 58	
17. INFORMANT MRS GARY MEADOWS 395A MAPLE AVE JESSUP MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of the chest 919.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject shot accidentally	
20c. TIME OF INJURY Month, Day, Year Hour a.m. Ref. 4:00 10 11 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work 2	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Reisterstown Balto Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B STEWERT F. WILSON		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED 10/12/67		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT 15 1967	
23c. NAME OF CEMETERY OR CREMATORY NEW BETHEL CEM		23d. LOCATION (City or Town) (County) (State) CLINTON N.C.	
24. FUNERAL DIRECTOR THE VIPPEL BROS INC 1800 E LOMBARD ST		25a. REC'D BY REGISTRAR OCT 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S SIGNATURE	

1000

MINERAL EXAMINER, JOURNAL OF MINES

1914

FOR SALE

England

France

Belgium

France

United States

Canada

United States

Canada

Belgium

France

May 1914

May 1914

May 1914

May 1914

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May 1914

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May 1914

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13492

13497

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Balto.				c. LENGTH OF STAY IN 1b 50 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4119 Taylor ave.				d. STREET ADDRESS 4119 Taylor Avenue			
3. NAME OF DECEASED (Type or print) John Roedel Jaeger				4. DATE OF DEATH Month 10 Day 4 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-14-1911	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist			10b. KIND OF BUSINESS OR INDUSTRY Allied Research		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John T. Jaeger				14. MOTHER'S MAIDEN NAME Annie Higdon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT E. Eleanor Jaeger 4119 Taylor Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.				22. DATE SIGNED 10/16/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/9/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d. LOCATION (City or Town) (County) (State) Balto. Balto. Md.		
24. FUNERAL DIRECTOR Lassahn Funeral Home 2401 Belair Road				25a. REC'D BY REGISTRAR DATE OCT 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13493

13498

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BALTO. Co. Gen. Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO</u> <u>ZONE 21307</u> d. STREET ADDRESS <u>8343 Church Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Morris L</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>14</u> - Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-15-92</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Harold Jaffe</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>213-34-1096</u>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured abdominal aortic aneurysm</u> DUE TO (b) <u>451x</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>N.B. - Exploratory laparotomy - performed.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 13, 1967</u> to <u>Oct 14, 1967</u> that (I) (we) last saw the deceased alive on <u>Oct 14, 1967</u> and that death occurred at <u>3:10 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Fedor C. Caguin</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>FEDOR C. CAGUIN</u>		22d. ADDRESS <u>8811 Liberty Rd. Randallstown Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/15/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Workmen Circle</u>	23d. LOCATION (City, town or county) (State) <u>BALTO Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sylvan S. Lewis & Son, Inc</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25a. ADDRESS <u>15M 7-62</u>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1947

CENTRAL DE MATH

1947

Handwritten notes and calculations, including the word "Group" and various numbers.

Handwritten notes and calculations, including the word "Group" and various numbers.

Handwritten notes and calculations, including the word "Group" and various numbers.

Handwritten notes and calculations, including the word "Group" and various numbers.

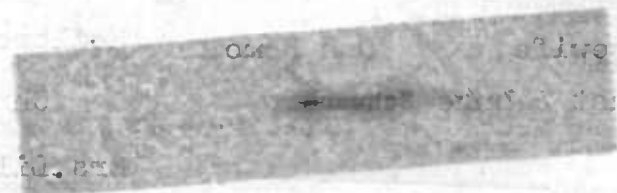
Handwritten notes and calculations, including the word "Group" and various numbers.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

Item 13 FilmG 434		MARYLAND STATE DEPARTMENT OF HEALTH	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 13494		13494	
3/31/71 jmj		CERTIFICATE OF DEATH	
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkton c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt. Carmel Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkton d. STREET ADDRESS Mt. Carmel Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Marie Last Jahnke		4. DATE OF DEATH Month October Day 23 Year 1967	
5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 24, 1887 9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (County & State, or foreign country) Heilbronn A'N Germany 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME August Jahnke Schmitt 14. MOTHER'S MAIDEN NAME Christine Bierbach			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. No 17. INFORMANT Mrs. Lillian P. Smith Address (Same)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis G V Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Jan 1964 , 19 to 10/23 , 19 67 that (I) (we) last saw the deceased alive on 10/22 , 19 67 , and that death occurred at 7:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE C. Herbert Mueller 22c. PHYSICIAN'S NAME (Type) C. HERBERT MUELLER, Jr.		22b. DATE SIGNED 10/23/67 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10/25/1967 23c. NAME OF CEMETERY OR CREMATORY Parkwood 23d. LOCATION (City, town or county) (State) Parkville, Balto. Co. Md.		25a. REC'D BY REGISTRAR OCT 24 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

13481



After 2 hours CV shown
Bureau's question

✓
10/23/67
C. Herbert Munnell
10/22/67
PARK TO E, M.A.

DEC 2 4 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

13495

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13500

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa, 21085	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jennie Middle Janda Last Janda		4. DATE OF DEATH Month October Day 7 Year 1967	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1886
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vaclav MARES		14. MOTHER'S MAIDEN NAME Johanna	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220 44 843651	
17. INFORMANT Edward Janda		Address 2518 E. Monument St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebro-Vascular Thrombosis DUE TO (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 30 , 19 67 , to October 7 , 19 67 , that (I) (we) last saw the deceased alive on October 7 , 19 67 , and that death occurred at 1:00a M, from causes and on the date stated above.			
22a. SIGNATURE Beatriz P. Dizon M.D.		22b. DATE SIGNED October 7, 1967	
22c. PHYSICIAN'S NAME (Type) Beatriz P. Dizon, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 10, 1967	23c. NAME OF CEMETERY OR CREMATORY Bohemian National Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Philip E. Cuch		25a. REC'D BY REGISTRAR OCT 10 1967	
ADDRESS 1211 Chesaco Ave.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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DEPARTMENT OF DEFENSE

SECURITY

SECURITY

1. NAME OF THE PERSON OR ENTITY		2. ADDRESS	
3. PHONE NUMBER		4. FAX NUMBER	
5. E-MAIL ADDRESS		6. WEBSITE	
7. TYPE OF ORGANIZATION		8. DATE OF ESTABLISHMENT	
9. TYPE OF ACTIVITY		10. DATE OF ACTIVITY	
11. TYPE OF INFORMATION		12. DATE OF INFORMATION	
13. TYPE OF DOCUMENT		14. DATE OF DOCUMENT	
15. TYPE OF RECORD		16. DATE OF RECORD	
17. TYPE OF FILE		18. DATE OF FILE	
19. TYPE OF COPY		20. DATE OF COPY	
21. TYPE OF PRINT		22. DATE OF PRINT	
23. TYPE OF PHOTO		24. DATE OF PHOTO	
25. TYPE OF VIDEO		26. DATE OF VIDEO	
27. TYPE OF AUDIO		28. DATE OF AUDIO	
29. TYPE OF OTHER		30. DATE OF OTHER	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13496

13501

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - HARRISON</u>		c. LENGTH OF STAY in 1b <u>26 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forever Nursing Home</u>		d. STREET ADDRESS <u>3004 Resaland Ave #15</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sophie Taslow</u>		4. DATE OF DEATH <u>10-30-67</u>	
First Middle Last		Month Day Year	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1892</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>RUMANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Milton Greenberg</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-36-3210</u>	
17. INFORMANT <u>MR. Morris Taslow</u>		Address <u>3608 CLARKS LANE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ASCVD, CVA suspected</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>July</u> , 19 <u>67</u> to <u>Oct 30</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Oct. 30, 1967</u> , and that death occurred at <u>1:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Leon S. Sheer</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>LEON S. SHEER, M.D.</u>		22d. ADDRESS <u>6715 PARK HEIGHTS AVE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-1-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MARYLAND LODGE</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD</u>		25a. REC'D BY REGISTRAR <u>NOV 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10001

DEPARTMENT OF STATE

2412

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13502									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL, and give nearest town) <u>Baltimore Town</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>9 W. 2nd Ave. (Balto. 25)</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>					d. STREET ADDRESS <u>9 W. 2nd Ave</u> 02-2				
3. NAME OF DECEASED (Type or print) First <u>INIA</u> Middle Last <u>Jeffrey</u>					4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1967</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/17/78</u>		9. AGE (In years last birthday) <u>89</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME <u>BENJAMIN BOYER</u>					14. MOTHER'S MAIDEN NAME <u>BARNESKEY</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>216-46-2256</u>		17. INFORMANT Address <u>PATIENT'S CHART</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> <u>4331</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Cardio Vascular disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonia involving whole @ lung, DIABETES MELLITUS</u>								INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/17</u> , 19 <u>67</u> , to <u>10/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/18</u> 19 <u>67</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Derek A Bruce</u>					22b. DATE SIGNED <u>10/18</u>				
22c. PHYSICIAN'S NAME (Type) <u>DEREK A BRUCE</u>					22d. ADDRESS <u>G.B. M.C</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md</u>			
24. FUNERAL DIRECTOR <u>Robert Brown</u> <u>Singleton Funeral Home / Glen Burnie, Md.</u>				25a. REC'D BY REGISTRAR <u>OCT 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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OCT 20 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Item 2 Film 393 P MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13498 CERTIFICATE OF DEATH 13503

1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY CATONSVILLE, BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1b 12 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CATON RIDGE NURSING HOME		d. STREET ADDRESS 329 HARLEM AVE	
3. NAME OF DECEASED (Type or print) HELEN		4. DATE OF DEATH Month 10 Day 16 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/82
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LIBRARIAN		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) BALTO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 214-54-2213	
17. INFORMANT John Fisher		Address 333 Harlem Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Cardiovascular Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar 1966 , to 10/15, 1967 , that (I) (we) last saw the deceased alive on 10/15, 1967 , and that death occurred at 8:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Paul E. Zichy		22b. DATE SIGNED 10/16/67	
22c. PHYSICIAN'S NAME (Type) Paul E. Zichy		22d. ADDRESS 4115 N. Lane Ellwood City, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF OCT 16 1967	
23c. NAME OF CEMETERY OR CREMATORY St. Vincent's Cemetery		23d. LOCATION (City, town or county) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Frank J. Jenkins		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 17 1967	

JENKINS FUNERAL HOME, BALTIMORE, MD.

1981

1981

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1981

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13498

13504

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shady Nook Nursing Home</u>			d. STREET ADDRESS <u>5203 Gwyn Oak Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Dr. Clinton P. Johnson</u>			4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1880</u>		9. AGE (In years last birthday) <u>87</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-38-4647A</u>		17. INFORMANT <u>Carroll C. Woodrow</u> Address <u>2621 Longwood Dr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, right lung</u> DUE TO (b) _____ stating the underlying cause last. (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/7</u> , 19 <u>67</u> , to <u>10/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/27</u> 19 <u>67</u> , and that death occurred at <u>5 P.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>D. C. MacLaughlin</u>			22b. DATE SIGNED <u>10/30/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. D. C. MacLaughlin</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>10/31/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>
23d. LOCATION (City or Town) <u>Balto. Md.</u>			23e. REC'D BY REGISTRAR <u>OCT 30 1967</u>		23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
24. FUNERAL DIRECTOR <u>Witzke</u>			ADDRESS <u>4101 Edmondson Ave. Balto. Md.</u>		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13500

CERTIFICATE OF DEATH

13505

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY in lb <u>5 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Md. Masonic Home</u>		d. STREET ADDRESS <u>2751 Maryland Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ida Nessel Jones</u>		4. DATE OF DEATH Month Day Year <u>October 3 1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 17, 1887</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter F.B. Nessel</u>		14. MOTHER'S MAIDEN NAME <u>Anna M Niekle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-03-5399</u>	
17. INFORMANT <u>Records of Md. Masonic Home</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary artery occlusion</u> DUE TO (b) <u>3 Anterior cerebral heart disease</u> DUE TO (c) <u>3 Congestive heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 13, 1965</u> to <u>Oct 2, 1967</u> that (I) (we) last saw the deceased alive on <u>Oct 3, 1967</u> , and that death occurred at <u>11:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>James H. Hamed</u>		22b. DATE SIGNED <u>10/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James H. Hamed, M.D.</u>		22d. ADDRESS <u>MASONIC HOME, Cockeysville</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery, Pikesville, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>1000 Cork-Burke Town</u>		25a. REC'D BY REGISTRAR <u>1050 York Rd</u>	
25b. REGISTRAR'S SIGNATURE <u>Tobson & Md</u>		25c. REC'D BY REGISTRAR <u>OCT 6 1967</u>	
25d. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13501

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13506

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21), XXXXX		c. LENGTH OF STAY IN 1b 03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1407 Eastern Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH A. JONES		4. DATE OF DEATH Month Day Year October 15, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/55
9. AGE (In years last birthday) 12 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William A. Jones, Jr.	
14. MOTHER'S MAIDEN NAME Edna McVicker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT William A. Jones, Jr. Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution 914.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Electrocuted by 11,000 volt Railroad Line	
20c. TIME OF INJURY Hour 4:51 p.m. Month, Day, Year 10/15 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rail Road Tracks	20f. (City or town) (County) (State) Twin River, Chase, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 10/16/67	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		23. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/18/67	
23c. LOCATION (City or Town) (County) (State) Glen Burnie, Md.		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR Bruzdinski Funeral Home 1407 Eastern Ave.		25a. REC'D BY REGISTRAR OCT 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13502

CERTIFICATE OF DEATH

13507

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b <u>7 wks</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conway</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater BALTO med Center</u>				d. STREET ADDRESS <u>1001 Eastridge Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA MAE KASNIC</u>				4. DATE OF DEATH Month Day Year <u>Oct 26 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/22/14</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Ambridge, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Peter Kasarich</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kerchowicz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>211-32-1618</u>		17. INFORMANT <u>Joseph T. Kasnic, 1001 Eastridge Ave</u>		Address <u>Conway, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> DUE TO (b) <u>Brain metastasis of Breast Cancer</u> stating the underlying cause last. (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/11/1967</u> , to <u>10/26/1967</u> , that (I) (we) last saw the deceased alive on <u>10.26.1967</u> , and that death occurred at <u>LUSAM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>N. Elstner</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>10.26.67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. NASSER EFTEKHARI</u>				22d. ADDRESS <u>GBMC - BALTO. Lawrence Co.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Little Beaver Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Little Beaver Township Pa</u>	
24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>				25a. REC'D BY REGISTRAR <u>Oct 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

4.2

Brain metastases of breast cancer

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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13503

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13508

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1145 GRANVILLE RD</u>		d. STREET ADDRESS <u>1145 GRANVILLE RD</u>	
3. NAME OF DECEASED (Type or print) First <u>KATHERINE</u> Middle <u>D.</u> Last <u>KAVANAUGH</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 27, 1890</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.F. & G.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>JOHN J. KAVANAUGH</u>	
14. MOTHER'S MAIDEN NAME <u>BRIDGET MURRAY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary Kavanagh - 1145 Granville Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ABDOMINAL CARCINOMATOSIS</u> <u>1992</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>ALCOHOL-INDUCED MYOHEART</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> , 19 <u>66</u> , to <u>10/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/30</u> , 19 <u>67</u> , and that death occurred at <u>Home</u> , from/causes and on the date stated above.			
22a. SIGNATURE <u>John H. Shaw</u>		22b. DATE SIGNED <u>10/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u>		22d. ADDRESS <u>850 Edmonson Ave. NW - 18, 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11-3-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>Foley, Conway & Co. - Catonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

2001

REPORT OF DEATH

01110

DEATH CERTIFICATE

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
13504 Item #9 Film #G391 10/27/67 ph 13509													
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY Baltimore						a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center						d. STREET ADDRESS Loch Raven Blvd.							
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH							
First Middle Last HAZEL Harrison KEEN						Month Day Year 10 19 1967							
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/29/90		9. AGE (In years last birthday) 77 78/ yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Issac Harrison						14. MOTHER'S MAIDEN NAME Gill ?							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Family records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1538</i> Pulmonary emboli Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Peritonitis DUE TO (c) Carcinoma of colon PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>8/25</i> , 1967, to <i>10/19</i> 1967, that (I) (we) last saw the deceased alive on <i>10/19</i> 67, and that death occurred at <i>3:35</i> AM, from the causes and on the date stated above.													
22a. SIGNATURE <i>John E. Adams</i>						ATTENDING PHYS. <input type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/19/67					
22c. PHYSICIAN'S NAME (Type) John E. Adams, M. D.						22d. ADDRESS Greater Baltimore Medical Center							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 21, 1967		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery				23d. LOCATION (City, town or county) (State) Woodlawn, Balto. Co., Md.					
24. FUNERAL DIRECTOR <i>John Burns Sons</i>		ADDRESS Towson		25a. REC'D BY REGISTRAR DATE OCT 23 1967		25b. REGISTRAR'S SIGNATURE <i>Richard Judge</i>							

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LIBRARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13505

CERTIFICATE OF DEATH

13510

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 1527 Winston Road #21212 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine M. Keller First Middle Last		4. DATE OF DEATH October 10, 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-19-1890 9. AGE (In years last birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Robert Stack		14. MOTHER'S MAIDEN NAME Julia Butler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Kathleen C. Keller, 1527 Winston Rd. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia. 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from 10-10- , 19 67 , to 10-10- , 19 67 , that (H) (we) last saw the deceased alive on 10-10- , 19 67 , and that death occurred at 11:30 a.m. , from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED October 10, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela - Gomez, M.D.		22d. ADDRESS 7620 York Road, Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-14-67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Balto., Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd. ADDRESS		25a. REC'D BY REGISTRAR OCT 11 1967 DATE	
		25b. REGISTRAR'S SIGNATURE [Signature]	

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STATEMENT OF DEBIT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
13506		13511	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. CITY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, 28		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City - 19, Md. - Edgemere 031	
c. LENGTH OF STAY IN 1b since May 27, 67		d. STREET ADDRESS 2121 Lodge Forest Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Vida Frances KELLER		4. DATE OF DEATH Month Oct. Day 8 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH August 8, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of last year) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 71
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Abraham Thomas		14. MOTHER'S MAIDEN NAME Lydia ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-12-5008	
17. INFORMANT Spring Grove Record		Address Catonsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Arteriosclerotic Heart Disease (Myocard. Infarction) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost. Generalized Arteriosclerosis (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Brain Tumor (Frontal lobe) (in evaluation.)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) n o n e	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 27, 1967 , to Oct. 8, 1967 , that (I) (we) last saw the deceased alive on October 8, 1967 , and that death occurred at 1: PM , from causes and on the date stated above.			
22a. SIGNATURE Imre Kopits, M.D.		22b. DATE SIGNED Oct. 8, 1967	
22c. PHYSICIAN'S NAME (Type) Imre Kopits, M.D.		22d. ADDRESS Spring Grove Hospital, Catonsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/11/67	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR DATE OCT 11 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY _____					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> State <u>21218</u> <u>30-4</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Armocost Nursing Home</u>						d. STREET ADDRESS <u>1504 Lakeside Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lillian E. Kelly</u>						4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1967</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 8, 1882.</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Eckardt</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Silkman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-14-5488</u>		17. INFORMANT <u>Mrs. Oscar Hessler</u> Address <u>(Same)</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>ARTERIO SCLEROTIC CV DISEASE</u> DUE TO (c) <u>ARTERIOSCLEROSIS-GENERALIZED</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10 YEARS +</u> <u>11</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HEMI PLEGIA - CEREBRAL THROMBOSIS - OLD</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>OCT. 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>SEPT. 21</u> , 19 <u>67</u> , and that death occurred at <u>9:00 AM</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>Arthur Karfagin</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/4/67.</u>			
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR KARFAGIN M.D.</u>						22d. ADDRESS <u>1532 HAVENWOOD ROAD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/7/67.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore, Nemeter</u>				23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>OCT 5</u> 19 <u>67</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>			

10/1/67

CENTRAL OF MICHIGAN

Salisbury Road 21218

1504 Lakeside Avenue

March 8, 1968

USA Maryland

Postoffice

Elizabeth Stinson

John Eckardt

217-11-2488 Mr. Oscar Hansen (same)

no

10/1/67

Salisbury, Md.

Salisbury, Maryland

10/1/67

Central

10/1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13508

13513

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EAST POINT		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EAST POINT ESSEX	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 524 FAIRVIEW		d. STREET ADDRESS 629 WOODWARD	
3. NAME OF DECEASED (Type or print) MINNIE C. KIRCKHOFF		4. DATE OF DEATH Month OCT Day 25 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 24, 1884
9. AGE (In years lost birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) BALTO. MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN AULT		14. MOTHER'S MAIDEN NAME ANNA RUBUPELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT THELMA GOVER		Address 524 FAIRVIEW	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic heart disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/20, 1967 , to 10/25, 1967 , that (I) (we) last saw the deceased alive on 10/25, 1967 , and that death occurred at 3:28 PM , from causes and on the date stated above.			
22a. SIGNATURE B. M. Oteyza, M. D.		22b. DATE SIGNED 10/26/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 1012 Old North Point Road 21224	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/28/67	
23c. NAME OF CEMETERY OR CREMATORY OAK LAWN		23d. LOCATION (City or Town) (County) (State) BALTO. MD.	
24. FUNERAL DIRECTOR J. G. CONNELLY SONS		25a. REC'D BY REGISTRAR OCT 30 1967	
ADDRESS 300 MACE		25b. REGISTRAR'S SIGNATURE Charles Judge	

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RECEIVED
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO DIRECTOR
FROM SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]

RE NEW YORK TELETYPE TO BUREAU, OCTOBER 10, 1961.
[Illegible]

NEW YORK OFFICE IS CURRENTLY CONDUCTING AN INVESTIGATION
[Illegible]

THE RESULTS OF THIS INVESTIGATION WILL BE FURNISHED TO THE BUREAU
[Illegible]

VERY TRULY YOURS,
[Illegible]

ENCLOSURE
[Illegible]

NOV 1 1961
[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #7, 8 & 9 Film #G393 10/6/67 pn
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>-</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>111 West Road (Dulaney-Towson N.H.)</i>		d. STREET ADDRESS <i>3501 St. Paul St.</i>	
3. NAME OF DECEASED (Type or print) <i>Loretta H. Klenk</i>		4. DATE OF DEATH Month <i>Oct.</i> Day <i>2</i> Year <i>1967</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan, 16, 1889</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>1</i> Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Hall</i>		14. MOTHER'S MAIDEN NAME <i>-</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>213-01-0525</i>	
17. INFORMANT <i>Mr. Hall Klenk</i>		Address <i>106 Midhurst Rd. I2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hodgkin's Sarcoma, generalized</i> DUE TO (b) <i>201X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>2 mo.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 mo.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>5 May, 1967</i> to <i>2 Oct., 1967</i> that (I) (we) last saw the deceased alive on <i>2 Oct., 1967</i> , and that death occurred at <i>2:15 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Joseph E. Muse Jr.</i> M.D.		22b. DATE SIGNED <i>2 Oct. '67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Joseph E. Muse Jr.</i>		22d. ADDRESS <i>2725 N. Charles St. (18)</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>10/5/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cem.</i>	23d. LOCATION (City or Town) (County) (State) <i>Balto. Md.</i>
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc Baltimore, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 3 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1945

Delco

3501 St. Paul St.

W. S. A.

Delaware

Honolulu

John Hall

no

213-01-422 Mr. Hall Blank 100 Highway Rd. 15

Delco, W.

Baltimore Co.

10/5/57

Brief

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b NONE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Amoco Station - Taylor & Loch Raven		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle E. Last KNOX		4. DATE OF DEATH Month October Day 29 Year 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-1933
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months 34 Days 34 Hours 34 Min. 34	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTENDANT		10b. KIND OF BUSINESS OR INDUSTRY AMOCO STATION	
11. BIRTHPLACE (State or foreign, country) WILMINGTON, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT E. KNOX, SR.		14. MOTHER'S MAIDEN NAME LOSSIE SIDEBERRY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Walter Rhen		Address 6901 Lock Raven Blvd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemopericardium DUE TO stab wound of chest involving the heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed during a fight	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:00 xx 10/29 19 67		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Amoco Station		20f. (City or town) (County) (State) Baltimore, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type)		22. DATE SIGNED 10/29/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-2-67	
23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem Pl.		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Morton E Dyett F.H.		25a. REC'D BY REGISTRAR DATE NOV 1 1967	
25b. REGISTRAR'S SIGNATURE James J. Jones			

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5-2-1953

WASHINGTON, D.C.

AMERICAN STATION

FOR THE STATIONARY

ROBERT A. HENRY, JR.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13512

CERTIFICATE OF DEATH

13517

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1b 1200 BALTIMORE MD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MED. CENTER		d. STREET ADDRESS 1200 TUGWELL DR.	
3. NAME OF DECEASED (Type or print) First JULIA Middle B. Last KOCHER		4. DATE OF DEATH Month October Day 21 Year 1967	
5. SEX Female	6. COLOR OR RACE W. C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-87
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) AUSTRIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME MATHEW BAZEK		14. MOTHER'S MAIDEN NAME JOSEF POKA Katherine Scheick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-30-5096	
17. INFORMANT PATIENTS CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of vulva w 1760 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) Liver + peritoneal metastases DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombophlebitis, legs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-19- , 19 67 , to 10-21 , 19 67 that (I) (we) last saw the deceased alive on 10-21 19 67 , and that death occurred at 2:25 AM , from causes and on the date stated above.			
22a. SIGNATURE Jose M. de Leon M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOSE M. DE LEON, MD		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/24/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		25a. REC'D BY REGISTRAR 6500 York Rd.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 24 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13513

13518

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balto. Beltway I695 1/4 ml N. of Alt.		d. STREET ADDRESS 2805 Frederick Ave.	
3. NAME OF DECEASED (Type or print) ESTELLE KROMM		4. DATE OF DEATH Month October Day 6 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-16-1940
9. AGE (In years last birthday) 27 yrs.		10. IF UNDER 1 YEAR Months 27 Days 27 Hours 27 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES WOMEN		10b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES LADD		14. MOTHER'S MAIDEN NAME LUCILLE MORRIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-36-6118	
17. INFORMANT JAMES LADD		Address 416 S. STRICKER ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Subject, passenger in car into tractor trailer.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject, passenger in car into tractor trailer.		20b. TIME OF INJURY Month, Day, Year Hour a.m. 1:20 XXX 10 6 19 67	
20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20e. (City or town) Balto.		20f. (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson		22. DATE SIGNED October 6, 1967	
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		23. LOCATION (City or Town) (County) (State) BALTIMORE-MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-11-67	
23c. NAME OF CEMETERY OR CREMATORY LOUDDON PARK		23d. REC'D BY REGISTRAR 575.	
24. FUNERAL DIRECTOR WALTER S FUNERAL HOME		25. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS PRATT+STRICKER		DATE OCT 13 1967	

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UNITED STATES DEPARTMENT OF JUSTICE

1000 Pennsylvania Ave.

Washington, D.C. 20535

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13514

CERTIFICATE OF DEATH

13519

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3mth21dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 3014 Fairview Road	
3. NAME OF DECEASED (Type or print) First Max Middle Krout Last Krout		4. DATE OF DEATH Month Oct. Day 26 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1894
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 1 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) grocery store		10b. KIND OF BUSINESS OR INDUSTRY Russia	
11. BIRTHPLACE (County & State, or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Solomon Krout		14. MOTHER'S MAIDEN NAME Sarah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unk		16. SOCIAL SECURITY NO. 218-38-3902	
17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bilateral, lobar, organism undeter. 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Ht. Dis.; bacteremia with shock asso.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (If this hospital) attended the deceased from July 3, 1967 , to Oct. 26, 1967 , that (I) last saw the deceased alive on Oct. 26, 1967 , and that death occurred at 4:30 P.M. on causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i> M.D.		22b. DATE SIGNED 10/26/67 5:50	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/29/67	23c. NAME OF CEMETERY OR CREMATORY Charles Emmanuel City Chm	23d. LOCATION (City or Town) (County) (State) Balto Md
24. FUNERAL DIRECTOR SYLVAN LEWIS & SON GARRISON, M.D.		25. REC'D BY REGISTRAR OCT 30 1967	
26. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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OFFICE OF THE ADJUTANT GENERAL

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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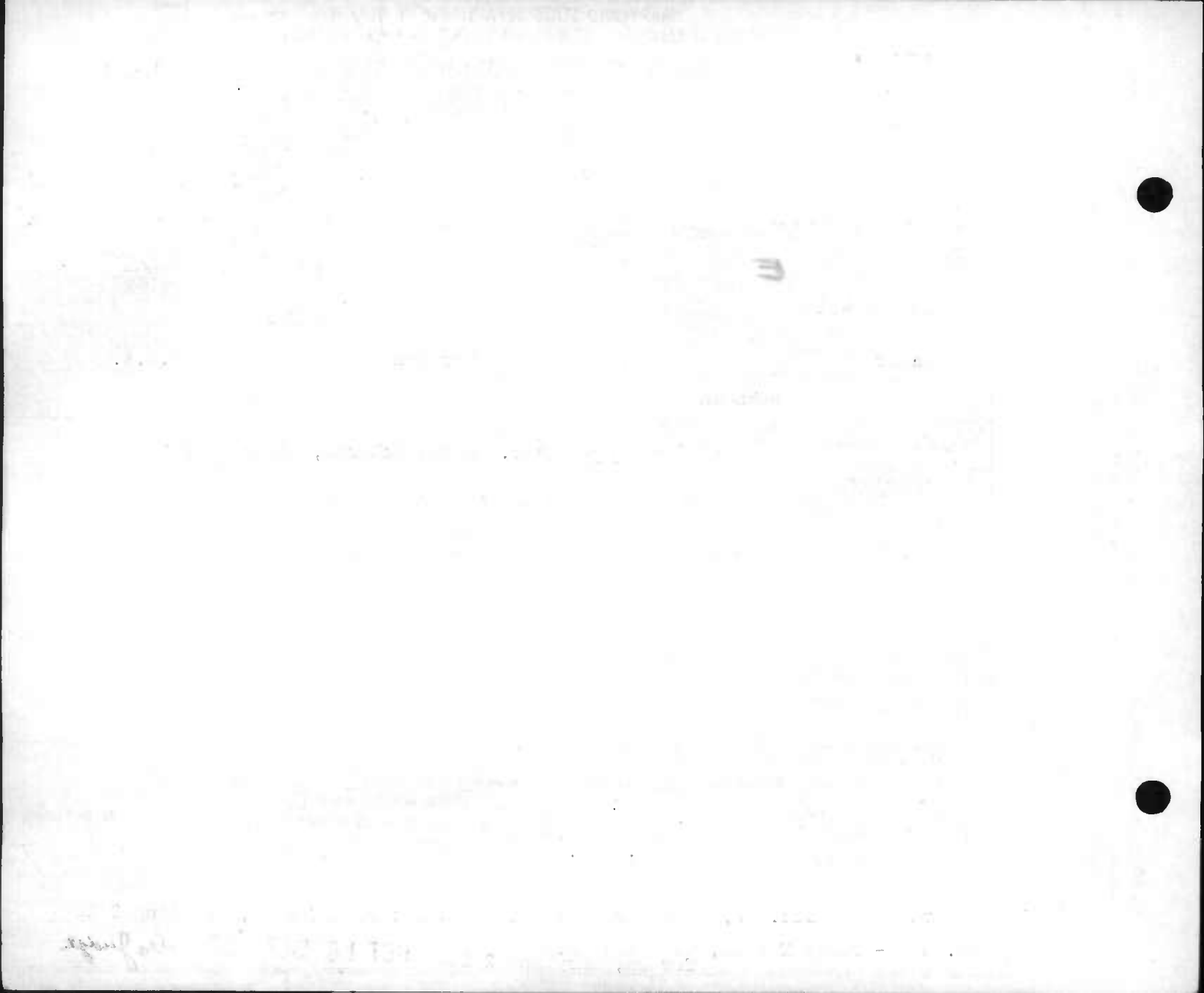
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13521

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b Years TOWSON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 609 VALLEY LANE		d. STREET ADDRESS 609 VALLEY LANE	
3. NAME OF DECEASED (Type or print) JESSE J. M. LAIRD		4. DATE OF DEATH OCT. 15 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 7 1904
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		12. KIND OF BUSINESS OR INDUSTRY Maryland	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-1632284	
17. INFORMANT Dr. George McLaren, Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Notural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE William A. Pillsbury		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) TOWSON MD.	
22. DATE SIGNED 10/15/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 17, 1967	
23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Towson, Maryland 21204	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204		25a. REC'D BY REGISTRAR OCT 18 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13516

CERTIFICATE OF DEATH

13522

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 3800 Monterey Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Alexander Joseph LANE		4. DATE OF DEATH Month Day Year October 30, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-13-1896
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY LAW	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME PETER LASTOWSKI		14. MOTHER'S MAIDEN NAME CATHERINE KISINGOLD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES. W.W.I		16. SOCIAL SECURITY NO. W.W.I	
17. INFORMANT Wm. C. Lane - 3800 Monterey Rd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive anterior septal myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary thrombosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Pulmonary thrombo embolism.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-22- , 19 67 , to 10-30- , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-30- , 19 67 , and that death occurred at 7 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Reynaldo Orjuela-Gomez, M.D.		22b. DATE SIGNED October 30, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-2-67	
23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL Cem.		23d. LOCATION (City or Town) (County) (State) BALTO. MD.	
24. FUNERAL DIRECTOR Stanley Miller - 2334 Jefferson St.		25a. REC'D BY REGISTRAR DATE NOV 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1981

UNITED STATES OF AMERICA

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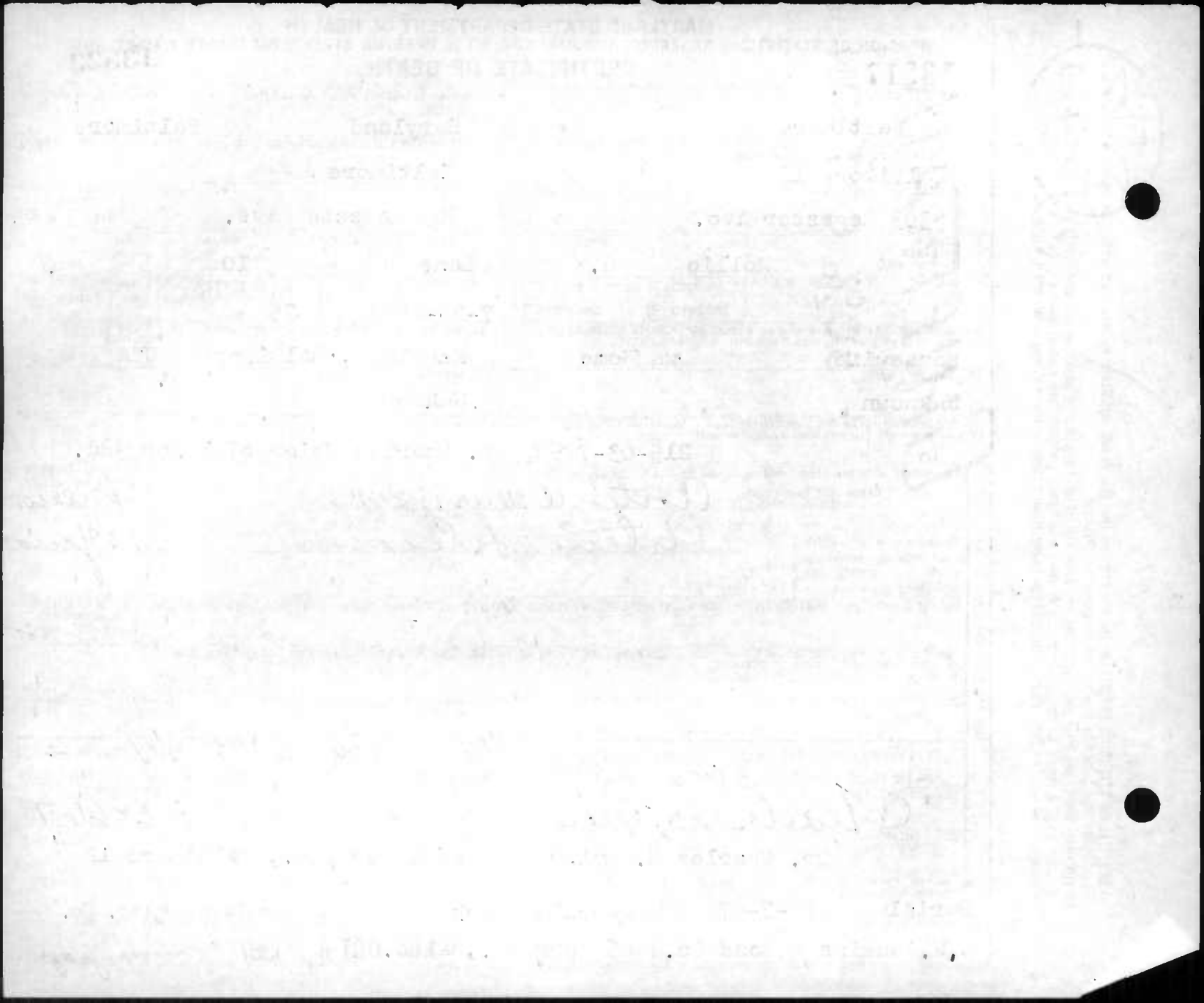
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13517
13523
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 12		c. LENGTH OF STAY IN 1b ?	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 303 Regester Ave.		d. STREET ADDRESS 303 Regester Ave.	
3. NAME OF DECEASED (Type or print) Mollie G. Lane		4. DATE OF DEATH Month 10 Day 5 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-28-1892
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-7958	
17. INFORMANT Dr. Charles Reier		Address 6701 York Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic aneurysm 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 4 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July , 19 36 , to 5 Oct , 19 67 , that (I) (we) last saw the deceased alive on 5 Oct , 19 67 , and that death occurred at 5 Oct M, from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Reier		22b. DATE SIGNED 5 Oct 67	
22c. PHYSICIAN'S NAME (Type) Dr. Charles H. Reier		22d. ADDRESS 6701 York Rd., Baltimore 12	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-7-67	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City, town or county) (State) Woodlawn Balto. Co.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR 4905 York Rd., Balto.	
25b. REGISTRAR'S SIGNATURE OCT 6 1967			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13518

CERTIFICATE OF DEATH

13524

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital or funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, Towson, Md. 21204				d. STREET ADDRESS 9001 Lodi Road, Balto., Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD C. LARTER				4. DATE OF DEATH Month Day Year October 29 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-10		9. AGE (In years last birthday) yrs. 57	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		10b. KIND OF BUSINESS OR INDUSTRY Govans Chev.		11. BIRTHPLACE (County & State, or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Larter				14. MOTHER'S MAIDEN NAME Annie Cromwell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W W 11		16. SOCIAL SECURITY NO. 174-05-3535		17. INFORMANT Mrs Jean K. Larter 9001 Lodi Road 21236			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction - old and recent 4201 "DUE TO" Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from 10-21 , 19 67 , to 10-29 , 19 67 , that (we) last saw the deceased alive on 10-29 , 19 67 , and that death occurred at 3:12 PM , from causes and on the date stated above.							
22a. SIGNATURE Ines Cilliani				22b. DATE SIGNED 10-29-67		22c. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.	
22d. ADDRESS 7620 York Road, Baltimore, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-1-1967		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Balto Md.	
24. FUNERAL DIRECTOR Lassahn Funeral Home 2401 Belair Road				25a. REC'D BY REGISTRAR DATE NOV 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13519 CERTIFICATE OF DEATH 13525

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center							
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth I. Lascola				4. DATE OF DEATH Month Day Year October 18 19 67			
5. SEX F		6. COLOR OR RACE Caus		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/27/07	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Husband (Vincent Lascola)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Lung Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 12, 19 67 to Oct 18, 19 67 , that (I) (we) last saw the deceased alive on Oct 19, 19 67 , and that death occurred at 8 A M, from the causes and on the date stated above.							
22a. SIGNATURE Michael Byerly				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) H Paul Byerly				22d. ADDRESS 3820 York Rd			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial		21 Oct 67		New Cathedral		Baltimore Md	
24. FUNERAL DIRECTOR Witzke Funeral Dir 4101 Emden				25a. REC'D BY REGISTRAR OCT 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13520

CERTIFICATE OF DEATH

13526

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 3844 The Alameda		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY		First Middle Last H. LAZZELL		4. DATE OF DEATH October 20, 1967		Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/31/1908	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Piraino				14. MOTHER'S MAIDEN NAME Josephine Imbrogulio			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Charles B. Lazzell (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of right breast with massive metastases 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from Oct. 9, 1967 , to Oct. 20, 1967 , that the (we) last saw the deceased alive on Oct. 20, 1967 , and that death occurred at 7:15 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Lawrence F. Misanik</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/21/1967	
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M. D.				22d. ADDRESS 7620 York Road, Towson 4, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/25/1967		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.				ADDRESS 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR DATE OCT 23 1967	
				25b. REGISTRAR'S SIGNATURE <i>William Judge</i>			

25.00

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201



13521

CERTIFICATE OF DEATH

13527

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Queen Annes			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 71 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grasonville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital					d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First WILLIAM Middle EZEKIEL Last LEGG				4. DATE OF DEATH Month OCTOBER Day 21 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/19/29		9. AGE (In years last birthday) yrs. 38	10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Chester, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Oscar M. Legg				14. MOTHER'S MAIDEN NAME Florence F. Hunter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes PL28			16. SOCIAL SECURITY NO. 214-28-35-08		17. INFORMANT Address Clin.Rec. VA Hospital, Fort Howard, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE 178x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF TESTES WITH GENERAL METASTASIS DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH HOURS UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour "a.m." 19 p.m. 			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from Aug. 11 , 19 67 , to Oct. 21 , 19 67 , that we (we) last saw the deceased alive on Oct. 21 , 19 67 , and that death occurred at 8:30PM from causes and on the date stated above.							
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) RODOLFO G. MIRO, M.D.					22b. DATE SIGNED 10/22/67		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 24		23c. NAME OF CEMETERY OR CREMATORY STEVENSVILLE		23d. LOCATION (City or Town) (County) (State) Stevensville, Maryland	
24. FUNERAL DIRECTOR Edgar L. Lane ADDRESS Lane Funeral Home Chester, Maryland				25a. REC'D BY REGISTRAR OCT 24 1967		25b. REGISTRAR'S SIGNATURE 	

Green Anne

Maryland

Baltimore

Green Anne

Fort Howard

Veteran Administration Hospital

07

OCTOBER 21

LEGG

EXEMPT

WILLIAM

36

2/2/72

XX

White

Male

U.S.A.

Chester, Maryland

Constitution

Current

Florence F. Hunter

Geor. H. Legg

218-25-35-06 Clin. Rec. VA Hospital, Fort Howard, Maryland

1938

Yes

HOURS

CARDIO-RESPIRATORY FAILURE

UNKNOWN

CARCINOMA OF TESTES WITH GENERAL METASTASIS

07

OCT. 21

8:30AM

Aug. 11

X

OCT. 21

X

IX 10/27/67

VA HOSPITAL, FORT HOWARD, MARYLAND

ROBERTO G. NIRO, M.D.

Stevensville, Maryland

Chester, Maryland

Jane Funeral Home

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cwings Mills</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxliegh Nursing Home</u>		d. STREET ADDRESS <u>11198 Reisterstown Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>Albert</u> Last <u>Lehmann</u>		4. DATE OF DEATH Month <u>10</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1886</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baltimore transit - street cars</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony A. Lehmann</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Nick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213 05-9144</u>	
17. INFORMANT <u>Mr. Arthur Lehmann, 26 Aglesham Rd, Timonium, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - prostate c metastasis</u> DUE TO <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>67</u> , to <u>October 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>October 10</u> , 19 <u>67</u> , and that death occurred at <u>7:45 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Clarence E. McWilliams MD.</u>		22b. DATE SIGNED <u>10-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u>11904 Reisterstown Rd Reisterstown Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Oct. 10, 1967</u>		23b. DATE THEREOF <u>Oct. 10, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Garrison Forest Park, Md.</u>	
24. FUNERAL DIRECTOR <u>Frank H. Henkel, Pikesville, Md.</u>		25. RECEIVED BY REGISTRAR <u>Charles Judge</u>	
26. REGISTRAR'S SIGNATURE <u> </u>		27. DATE <u>OCT 13 1967</u>	

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text appears to be a legal document or contract, with various lines of text and possibly a signature area.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13522 CERTIFICATE OF DEATH 13529											
Item #9 Film #0393 10/9/67 pn											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 416 Shady Nook Ave					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 416 Shady Nook Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Lizzie First May Middle Lenox Last 4. DATE OF DEATH Oct. Month 4 Day 1967 Year					5. SEX Female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Feb. 14 1886 9. AGE (In years last birthday) 81 86 yrs. IF UNDER 1 YEAR Months 7 Days 20 Hours Min. 						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) St. Petersburg Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Marshall Fowell					14. MOTHER'S MAIDEN NAME Mary E. Utterback						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)					16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary C. Derrickson Address 416 Shady Nook Ave.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Hypertensive Intracerebral Cerebral Vascular Dis. DUE TO (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus										INTERVAL BETWEEN ONSET AND DEATH 1 da. 20 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1-11- , 19 45 , to 10-4 , 19 67 , that (I) (we) last saw the deceased alive on 10-1-1967 , and that death occurred at 1 P. M, from the causes and on the date stated above.											
22a. SIGNATURE Wilmer K. Gallagher					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-5-67				
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher					22d. ADDRESS 6209 Frederick Ave. Balt 21228, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/7/1967		23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		23d. LOCATION (City, town or county) (State) Balto Md.				
24. FUNERAL DIRECTOR Farley Cavanaugh -6601 Frederick Ave.					25a. REC'D BY REGISTRAR OCT 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge				

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
13524					13530										
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)										
a. COUNTY Baltimore			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Med. Center					e. STREET ADDRESS 2212 Arden Road										
3. NAME OF DECEASED (Type or print) Frank Bertram Levi			4. DATE OF DEATH 10 5 19 67												
5. SEX Male		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-27-14		9. AGE (In years last birthday) 53 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Controller			10b. KIND OF BUSINESS OR INDUSTRY Baer Paper Co.			11. BIRTHPLACE (County & State, or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Max Levi					14. MOTHER'S MAIDEN NAME Meyer, JULIETTE										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) XXXXXX W, W, 11 ARMY					16. SOCIAL SECURITY NO. 218-10-8025					17. INFORMANT MRS. AUDREY T. LEVI					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure 2021 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Lymphoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from 8 . 6 , 19 67 to 10 . 5 , 19 67 , that (I) (we) last saw the deceased alive on 10 . 5 , 19 67 , and that death occurred at 8:40 PM , from the causes and on the date stated above.										22b. DATE SIGNED 10/5/67					
22a. SIGNATURE Shahm					22c. PHYSICIAN'S NAME (Type) Shahm					22d. ADDRESS M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION			23b. DATE THEREOF 10-8-67		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK			23d. LOCATION (City, town or county) (State) BALTIMORE, MARYLAND							
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD					25a. REC'D BY REGISTRAR OCT 9 1967					25b. REGISTRAR'S SIGNATURE Charles Judge					

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13525

CERTIFICATE OF DEATH

13531

1. PLACE OF DEATH a. COUNTY TOWSON BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE TOWSON		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 5506 Minnoka Ave. #21215	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle Levin Last Levin		4. DATE OF DEATH Month 10 Day 15 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/ 1906
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERINTENDENT		10b. KIND OF BUSINESS OR INDUSTRY Calvert Distillery Baltimore, Maryland	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC LEVIN		14. MOTHER'S MAIDEN NAME ANNA ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-22-4338	
17. INFORMANT MRS. DORA LEVIN, 5506 MINNOKA AVENUE #21215		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/13 , 19 67 , to 10/15 , 19 67 , that (I) (we) last saw the deceased alive on 10/15 , 19 67 , and that death occurred at 9:45M , from causes and on the date stated above.			
22a. SIGNATURE Ramon P. Lopez		22b. DATE SIGNED October 15, 1967	
22c. PHYSICIAN'S NAME (Type) Ramon P. Lopez, M.D.		22d. ADDRESS 7620 York Road Towson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-17-67	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD		25a. REC'D BY REGISTRAR 06F 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13526

13532

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE			c. LENGTH OF STAY IN TB			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUMMIT NURSING HOME				d. STREET ADDRESS 6625 FREDERICK AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle F. Last LITZENBERGER				4. DATE OF DEATH Month OCT. Day 22 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 6, 1898		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER		10b. KIND OF BUSINESS OR INDUSTRY TAVERN		11. BIRTHPLACE (County & State, or foreign country) PENN.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME LAWRENCE LITZENBERGER				14. MOTHER'S MAIDEN NAME CATHERINE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-5810		17. INFORMANT Mr. Lawrence Litzenberger - 6625 Frederick Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5810 Cerebrovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerotic CVD.						INTERVAL BETWEEN ONSET AND DEATH ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1967 , to Oct 22, 1967 , that (I) (we) last saw the deceased alive on Oct 21, 1967 , and that death occurred at 12 M, from causes and on the date stated above.							
22a. SIGNATURE J. C. Pound				22b. DATE SIGNED 10/23/67		22c. PHYSICIAN'S NAME (Type) J. C. Pound	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-23-67		23c. NAME OF CEMETERY OR CREMATORY QUAKERTOWN UNION CEM		23d. LOCATION (City or Town) (County) (State) QUAKERTOWN - PENN.	
24. FUNERAL DIRECTOR Volley - Coranay & H. Catonville Inc.				25a. REC'D BY REGISTRAR DATE OCT 25 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

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CERTIFICATE OF DEATH

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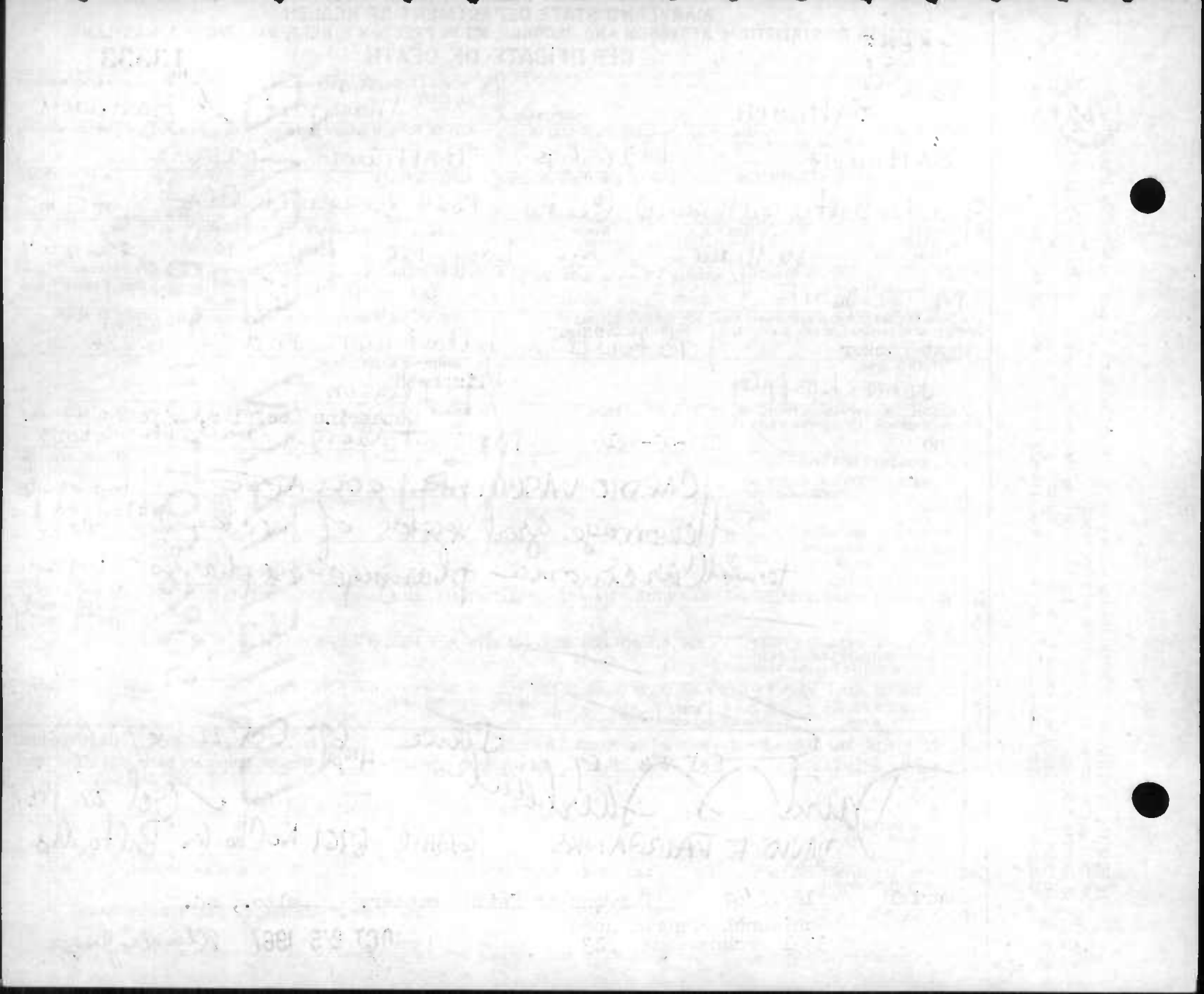
[Faint, mostly illegible text, likely a form or record, possibly containing names and dates.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13527						13533					
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>26 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 21206</u> d. STREET ADDRESS <u>1324 Rosewick Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>M.</u> Last <u>LOEFFLER</u>						4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-24-99</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat Packer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John Loeffler</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Peterson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>21B-03-9216</u>		17. INFORMANT <u>Catherine Loeffler, wife Same as Margaret Burger - Daughter - above</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO VASCULAR COLLAPSE</u> <u>1992</u> DUE TO <u>Hemorrhage great vessels of neck</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arterial Carcinoma pharyngo-esophagus</u> DUE TO <u>Arterial Carcinoma pharyngo-esophagus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>prolonged & slow</u> <u>~ 1 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> to <u>Oct 22</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>Oct 23</u> , 19 <u>67</u> , and that death occurred at <u>4¹⁵</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>David F. Fairbanks</u>						22b. DATE SIGNED <u>Oct 22, 1967</u>					
22c. PHYSICIAN'S NAME (Type) <u>DAVID F. FAIRBANKS</u>						22d. ADDRESS <u>G.B.M.C., 6701 No Charles, Balto. Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/26/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Balto., Md.</u>		
24. FUNERAL DIRECTOR <u>Schimunek Funeral Home</u> <u>3331 Brehms Lane #13</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



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VR A15 (4)
20 M 1/66

13528

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15021

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		c. LENGTH OF STAY IN 1b <u>4 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Villa Maria - Notch Cliff</u>				d. STREET ADDRESS <u>Glen - Arm</u>			
3. NAME OF DECEASED (Type or print) <u>Sister Mary Rufina Loesch</u>				4. DATE OF DEATH <u>10 / 31 / 1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1/27/1873</u>		9. AGE (In years lost birthday) <u>94</u> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>CONVENT</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ERIE, PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Loesch</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Anthony</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-54-3324 J</u>		17. INFORMANT <u>Se. Catherine Mary - Glen Arm 21057</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Generalized atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized atherosclerosis</u> (c) <u>Generalized atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 7</u> , 19 <u>66</u> , to <u>10/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>September 7</u> , 19 <u>67</u> , and that death occurred at <u>12:00 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Henry Brinkley</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 3, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sisters Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Arm Balt. Md.</u>	
24. FUNERAL DIRECTOR <u>Raymond J. Curran</u>				817 Scarlett Dr. Towson, Maryland 21204		25a. REC'D BY REGISTRAR <u>NOV 8 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

18021

CERTIFICATE OF DEATH

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U.S. DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

B 31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13529

CERTIFICATE OF DEATH

13534

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write nearest town) Baltimore				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summitt Nursing Home				d. STREET ADDRESS 1704 Cole St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hattie E. Luh				4. DATE OF DEATH Month October Day 7 Year 1967			
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH Nov. 10 1888	
9. AGE (In years and birth day) 78 yrs.		IF UNDER 1 YEAR Months 10 Days 7 Hours 18 Min.		11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME Frederick Schoenberger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Norbert Wheeler Address 519 Cleveland Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 157x Carcinoma of the pancreas = metast. to the liver IMMEDIATE CAUSE (a) 4 months DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May , 19 58 to 10.7 , 19 67 that (I) (we) last saw the deceased alive on 10.6 , 19 67 , and that death occurred at 100M , from causes and on the date stated above.							
22a. SIGNATURE John M. Lindner				22b. DATE SIGNED 10.9.67		22c. PHYSICIAN'S NAME (Type) J. KUDIRKA	
22d. ADDRESS 2151 Wilkins ave				22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 10/10/67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) (County) (State) Balto. Maryland	
24. FUNERAL DIRECTOR Witzke & Sons 4101 Edmondson Ave.				25a. REC'D BY REGISTRAR DATE OCT 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13530

13535

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8711 Summit 34		d. STREET ADDRESS 8711 Summit 34	
3. NAME OF DECEASED (Type or print) First CLAIRE Middle DANALEE Last LYNCH		4. DATE OF DEATH Month October Day 20 , Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/29/17
9. AGE (In years last birthday) yrs. 49		10. IF UNDER 1 YEAR Months 03 Days 1	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Stanley A. Thornburg	
14. MOTHER'S MAIDEN NAME Cora Silfies		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no no	
16. SOCIAL SECURITY NO. 154-12-2431		17. INFORMANT Mr. Leslie W. Lynch Address same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> October 20, 1967 Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10/23/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Park Cem.	23d. LOCATION (City or town) (County) (State) Balto. Md.
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.		25a. REC'D BY REGISTRAR DATE OCT 23 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13531

CERTIFICATE OF DEATH

13536

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY in lb 2 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAMPSTEAD			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS ROUTE #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LAWRENCE ASBERRY LYONS				4. DATE OF DEATH Month Day Year OCTOBER 9, 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/27/11	9. AGE (In years last birthday) yrs. 56	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) saw operator		10b. KIND OF BUSINESS OR INDUSTRY LUMBAR		11. BIRTHPLACE (County & State, or foreign country) NEWBURN, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM LYONS				14. MOTHER'S MAIDEN NAME VIOLA WEBB			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 412 09 84 16		17. INFORMANT Address CLINICAL RECORDS, VAH, FT. HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGIC PNEUMONIA, BILATERAL 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH RECENT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE WITH HYPERTENSIVE CARDIOVASCULAR DIS.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from OCT 7, 1967 to OCT 9, 1967 , that he (we) last saw the deceased alive on OCT 9, 1967 , and that death occurred at 4:45 AM , from causes and on the date stated above.							
22a. SIGNATURE <i>John D. Talbert</i>				22b. DATE SIGNED 10/9/67		22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.	
22d. ADDRESS VAH FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 12, 1967		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN CEMETERY		23d. LOCATION (City or Town) (County) (State) CARROLL COUNTY, MARYLAND	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR DATE OCT 13 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
ADDRESS TIPTON ELINE FUNERAL HOME				HAMPSTEAD, MARYLAND			

5-5

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DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13532

13537

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 606 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		304	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 5601 BIRCHWOOD AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle R. Last MAC CUBBIN		4. DATE OF DEATH Month OCTOBER Day 6 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/87
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE AGENT		10b. KIND OF BUSINESS OR INDUSTRY INSURANCE COMPANY	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM F. MAC CUBBIN		14. MOTHER'S MAIDEN NAME FRANCES E. STAYLOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 214 03 11 45	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL VASCULAR DISEASE DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS YEARS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 2/6/66 , 19__, to 10/6/67 , 19__, that (X) (we) lost saw the deceased alive on 10/6/67 19__, and that death occurred on 6:00A M, from causes and on the date stated above.			
22a. SIGNATURE <i>Chong Choon Han</i>		22b. DATE SIGNED 10/6/67	
22c. PHYSICIAN'S NAME (Type) CHONG CHOON HAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/10/67.	23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR RUCK FUNERAL HOME		25a. RECEIVED BY REGISTRAR OCT 9 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

HARFORD ROAD, BALTIMORE, MD.

13538

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

13533

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital (DOA)		d. STREET ADDRESS 27 Dublin Drive	
3. NAME OF DECEASED (Type or print) ARTHUR R. MACHESNEY		4. DATE OF DEATH Month October Day 6 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1904
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Design Engineer		10b. KIND OF BUSINESS OR INDUSTRY Martin-Marietta Co.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 169-05-9011	
17. INFORMANT Family information		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Hypertensive and arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Blunt impact to head with head and neck injuries			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs in front of factory	
20c. TIME OF INJURY Month, Day, Year 4:15 p.m. 10 6 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Factory steps		20f. (City or town) (County) (State) Middle River Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		22. DATE SIGNED 10-7-67	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 10, 1967	
23c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		23d. LOCATION (City or Town) (County) (State) Monkton, Maryland	
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		25a. OCTOBER 16 1967 DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1883

WEDNESDAY, JANUARY 31, 1883

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WEDNESDAY, JANUARY 31, 1883

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #12 Film #G393 10/13/67 ph

CERTIFICATE OF DEATH

13539

13534

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ridgeway Manor				d. STREET ADDRESS 2706 Joppa Rd			
3. NAME OF DECEASED (Type or print) First Joseph Middle Maggio Last Maggio				4. DATE OF DEATH Month OCT Day 4 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 OCT 1880		9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER				10b. KIND OF BUSINESS OR INDUSTRY RET.		11. BIRTHPLACE (County & State, or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME SALVATORE MAGGIO			
14. MOTHER'S MAIDEN NAME GIOVANINA VINZZINA				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			
16. SOCIAL SECURITY NO. ---				17. INFORMANT Address SAMUEL MAE 556 S. Rolling Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1900 , 1967, to 400 , 1967, that (I) (we) last saw the deceased alive on 4 OCT 1967, and that death occurred at 730 M , from causes on and on the date stated above.							
22a. SIGNATURE William Goodman				22b. DATE SIGNED 5 OCT 67		22c. PHYSICIAN'S NAME (Type) WILLIAM GOODMAN, M.D.	
22d. ADDRESS 133 + 2nd Street Rd - 21227				22e. REGISTRAR'S SIGNATURE Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-OCT-1967		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION (City or Town) (County) (State) BALTO. MD	
24. FUNERAL DIRECTOR E.S. MacNabb				25a. REC'D BY REGISTRAR OCT 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS 301 Frederick Rd				BALTO 21228 MD			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13535

13540

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE since Oct. 8, 1945 in this Hospital b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, Md. 21228		c. LENGTH OF STAY IN 1b since 1945.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS High Street			
3. NAME OF DECEASED (Type or print) Hazel First Middle Last MALINSKY				4. DATE OF DEATH Month Day Year October 8 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 26, 1894	
9. AGE (In years birthday) yrs. 73		10. KIND OF BUSINESS OR INDUSTRY housewife		11. BIRTHPLACE (County & State, or foreign country) unknown Iowa		12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME Samuel Stoneking				14. MOTHER'S MAIDEN NAME Florence Lowe			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-16-3655-T		17. INFORMANT Spring Grove Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia (about 5 days) DUE TO Arteriosclerotic Heart Disease (5 years +) DUE TO Generalized Arteriosclerosis (5 years +) DUE TO 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus and Central Nervous System Syphilis (20 yrs+)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 8, 1945 to Oct. 8, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 8 (9AM) 19 67 , and that death occurred at 9:30AM , from causes and on the date stated above.							
22a. SIGNATURE <i>S. Jurekovic</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Oct. 8, 1967	
22c. PHYSICIAN'S NAME (Type) Imre Kopits, M.D.				22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY The Anatomy Board of Maryland		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>Novell Funeral Home Pikesville - 899</i>				25a. RECEIVED BY REGISTRAR Oct 19 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>	

1953

Baltimore County

March 1953, 19 12 in the morning

Cocksville, Md. 21555 - March 1953

Spring Grove State Hospital

March

MARCH

Mar. 28, 1953

13

none

unknown low

unknown - low

11-10-53 - Spring Grove State Hospital

Brachycephalus (about 2 days)

Arctiophaga (about 2 days)

Conspicuous (about 2 days)

Disturbed (about 2 days)

none

Oct. 8, 1953

Oct. 8, 1953

9:00

Oct. 8, 1953

Oct. 8, 1953

Spring Grove State Hospital

Oct. 8, 1953

Oct. 8, 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13536

13541

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u>		c. LENGTH OF STAY IN 1b <u>30 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Armacost Nursing Home</u>		d. STREET ADDRESS <u>1522 Lakeside Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Regina</u> Middle <u>J.</u> Last <u>Mardaga</u>		4. DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1870.</u>
9. AGE (In years last birthday) yrs. <u>97</u>		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Mardaga</u>		14. MOTHER'S MAIDEN NAME <u>Mary Grob</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-56-3286-J1</u>	
17. INFORMANT <u>Mrs. Jessie M. Hoeck</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> DUE TO (b) <u>4500</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 6, 1967</u> to <u>Oct. 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct. 12, 1967</u> , and that death occurred at <u>5:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Loy M. Zimmerman</u>		22b. DATE SIGNED <u>10/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Loy M. Zimmerman M.D.</u>		22d. ADDRESS <u>3202 Hartford Rd., Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/19/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

11-331

CERTIFICATE OF DEATH

33-11

STATE OF NEW YORK
COUNTY OF []

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO VILLAGE

DATE OF ENTRY INTO TOWNSHIP

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTY

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DATE OF ENTRY INTO COUNTY

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13537

CERTIFICATE OF DEATH

13542

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 9yr8mth8days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 808 West Lombard Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Matus				4. DATE OF DEATH Month October Day 28 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1898		9. AGE (In years last birthday) yrs. 69	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Matus				14. MOTHER'S MAIDEN NAME Anile			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-22-8076		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, org. unk. DUE TO (b) Bronchitis, chronic DUE TO (c) 10 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Arteriosclerotic CVHD with atrial Fibrillation						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from Feb. 20 , 19 58 to Oct. 28 , 19 67 , that (A) (we) lost the deceased alive on Oct. 28 , 19 67 , and that death occurred at 6:40 M, from causes on and on the date stated above.							
22a. SIGNATURE <i>Anthony J. Young</i>				22b. DATE SIGNED 10-20-67		22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.	
22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/3/67		23c. NAME OF CEMETERY OR CREMATORY OAKLAND cem.		23d. LOCATION (City or Town) (County) (State) Phila. Phila. PA.	
24. FUNERAL DIRECTOR Norkas Funeral Home <i>Ed MacNabb</i>				25a. REC'D BY REGISTRAR NOV 3 1967		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13915

EXTRACT OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13538

CERTIFICATE OF DEATH

13543

Items #2c & d Film #G393 10/16/67 ph

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House in the Pines Nursing Home				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville d. STREET ADDRESS 5313 Edmondson Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First KATHERINE Middle L. Last MAUS				4. DATE OF DEATH Month Oct. Day 3 Year 1967									
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH August 17, 1874		9. AGE (In years last birthday) 93 IF UNDER 1 YEAR: Months 11 Days 11 IF UNDER 24 HRS.: Hours 11 Min. 11					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME George Myers				14. MOTHER'S MAIDEN NAME Annie E. Lefeure									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Richard Gilbert 506 Equitable Building									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema (b) and (c) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. A.G.C.V.D								INTERVAL BETWEEN ONSET AND DEATH Hrs Hrs. Years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from May 24, 1967, to 10/3/1967, that (I) (we) last saw the deceased alive on 10/3/1967, and that death occurred at 1 P.M. from the causes and on the date stated above.													
22a. SIGNATURE James A. Witzke M.D.								22b. DATE SIGNED 10/3/1967					
22c. PHYSICIAN'S NAME (Type)								22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/6/67		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City, town or county) Baltimore, Md.		(State)			
24 FUNERAL DIRECTOR'S SIGNATURE Witzke F. D. - 4101 Edmondson Ave.								25a. REC'D BY REGISTRAR DATE OCT 4 1967				25b. REGISTRAR'S SIGNATURE Charles J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10000

UNITED STATES OF AMERICA

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RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
MEMORANDUM
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows, mostly mirrored bleed-through from the reverse side of the page.]

100-100000
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
[Illegible text at the bottom of the page, including a date stamp and possibly a signature block.]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 21212	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Dominic McEvoy		4. DATE OF DEATH Month 10 Day 17 Year 1967	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/1907
9. AGE (In years last birthday) 59		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cartographer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter J. McEvoy		14. MOTHER'S MAIDEN NAME Anna Krestel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-09-7488	
17. INFORMANT Mrs. Beatrice W. McEvoy		Address (Same)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Carcinoma of lung DUE TO (c) _____ 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-14 , 19 67 , to 10-17 , 19 67 , that (I) (we) last saw the deceased alive on 10-17 , 19 67 , and that death occurred at 9:28M , from the causes and on the date stated above.			
22a. SIGNATURE John E. Adams		22b. DATE SIGNED 10/17/67	
22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D.		22d. ADDRESS 6701 N. Charles Street, Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/20/1967	
23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		23d. LOCATION (City, town or county) (State) Parkville, Balto. Co., Md	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR OCT 18 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Jones			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.									
13540 CERTIFICATE OF DEATH 13546									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Stoneleigh c. LENGTH OF STAY IN 1b 21 Mos. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Armacost Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1105 Elban Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Emma Middle R. Last McGee			4. DATE OF DEATH Month Oct. Day 8 Year 1967						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1890	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George McGee				14. MOTHER'S MAIDEN NAME Elizabeth Mark					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address Virginia McGee 6010 Falkirk Rd.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 1532 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) precipitated by ascending OUE TO (c) Calon								INTERVAL BETWEEN ONSET AND DEATH 6 weeks 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/11, 1967 to 10/8, 1967 , that (I) (we) last saw the deceased alive on 6 October, 1967 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Charles F. O'Donnell (M.D.) ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 10/10/67					
22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell				22d. ADDRESS 7301 York Rd. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-12-1967		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City, town or county) (State) Woodlawn, Md.			
24. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave.,				25a. REC'D BY REGISTRAR OCT 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13541

135417

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Woodlawn</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Co</u>		c. LENGTH OF STAY IN 1b <u>03-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1727 Langford Road 21207</u>		d. STREET ADDRESS <u>1727 Langford Road 21207</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank P Mc Kenna (McKenny)</u>		4. DATE OF DEATH Month Day Year <u>Oct 21 1967</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2 1875</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Eastern Box</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Mc Kenna</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Farley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217 26 2273</u>	
17. INFORMANT <u>Mrs. Wm. B Nolan, 1727 Langford Rd</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x</u> DUE TO <u>Cardio Vascular Renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>10/21, 1967</u> , that (I) (we) last saw the deceased alive on <u>10/17</u> 19 <u>67</u> , and that death occurred at <u>1:19</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>E. P. WILLIAMSON M.D.</u>		22b. DATE SIGNED <u>10/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>PROFESSIONAL ARTS BUILDING</u> <u>5550 BALTIMORE NATIONAL PIKE</u>		22d. ADDRESS <u>BALTIMORE 28, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-26-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR <u>Thomas J Kenny Inc 1600 Hollins St</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 25 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

521

TABLE 3

1

2007-01-15

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Items 20b, 20e, 21

Film #395
12-12-67 mt
13542

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13544

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarm				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarm			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Smith Farm Longreen Pike				d. STREET ADDRESS Smith Farm Longreen Pike			
3. NAME OF DECEASED (Type or print) First EDWARD Middle H. Last MCLEAN JR.				4. DATE OF DEATH Month October Day 22 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-4-1917		9. AGE (In years lost birthday) 20 yrs.	10. IF UNDER 1 YEAR Months 03 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caddy				10b. KIND OF BUSINESS OR INDUSTRY Selfemployed		11. BIRTHPLACE (State or foreign country) Baltimore Co. Md.	
13. FATHER'S NAME Edward McLean				14. MOTHER'S MAIDEN NAME Hilda Beares			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 213-52-6713		17. INFORMANT Mrs Harry Shackelford Address Kingsville, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 891.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carbon monoxide DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Unknown							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown			
20c. TIME OF INJURY Month, Day, Year Hour xx 10:30 p.m. 10-22 19 67				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown car	
				20f. (City or town) (County) (State) Glen Arm Balto. Md.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles S. Springate, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county) October 23, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-26-1967		23c. NAME OF CEMETERY OR CREMATORY Fork Methodist Cemetery		23d. LOCATION (City or Town) (County) (State) Fork, Md.	
24. FUNERAL DIRECTOR Lassal Funeral Home				25. REC'D BY REGISTRAR DATE OCT 27 1967		25b. REGISTRAR'S SIGNATURE Charles Jones	

14681

THE UNIVERSITY OF CHICAGO

1968 5 17 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13543

Item #4 Film #G393 10/16/67 ph

13548

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. BALTO.		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ESSEX			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ESSEX		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 14K HALL NURSING HOME			d. STREET ADDRESS 1322 WILSON PT. RD		
3. NAME OF DECEASED (Type or print) ROSE E McNeilly			4. DATE OF DEATH Oct. 3 1967		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/3/1896	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (County & State, or foreign country) NEW JERSEY		
10b. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JAMES FINN			14. MOTHER'S MAIDEN NAME EDITH TEMPLE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. MARY KNACKEL		
17. INFORMANT 202 STEVENS RD			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 331X DUE TO (b) Art. sclerotic cerebrovasc. disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes mell. ins.					INTERVAL BETWEEN ONSET AND DEATH 1 week 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that (I) (this hospital) attended the deceased from July 6 1965 to Oct 3 1967 , that (I) (we) last saw the deceased alive on Oct 3 1967 , and that death occurred at 3:20 PM , from the causes and on the date stated above.					
22a. SIGNATURE Louis Semenovff M.D.			22b. DATE SIGNED 10/3/67		
22c. PHYSICIAN'S NAME (Type) LOUIS SEMENOVFF			22d. ADDRESS 2108 OREMS RD BALTIMORE, MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/6/67	23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION (City, town or county) (State) BALTO. MD
24. FUNERAL DIRECTOR'S SIGNATURE J.G. CONNELLY SONS ADDRESS 300 MACE			25a. REC'D BY REGISTRAR OCT 9 1967 25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13544

15044

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 900 E. Joppa Road		d. STREET ADDRESS 900 E. Joppa Road	
3. NAME OF DECEASED (Type or print) First William Middle Herbert Last Medill		4. DATE OF DEATH Month Oct. Day 30 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1901
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 6 Days 1 Hours 1 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		12. KIND OF BUSINESS OR INDUSTRY Real Estate	
13. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME William F. Medill		16. MOTHER'S MAIDEN NAME Ellen Joynes	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		18. SOCIAL SECURITY NO. no	
19. INFORMANT Bessie G. Medill		Address 900 E. Joppa Rd.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic renal carcinoma 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/1/67 , 19 67 , to 10/30 , 19 67 , that (I) (we) last saw the deceased alive on 10/27/67 19 67 , and that death occurred at 6:20 P M, from causes and on the date stated above.			
22a. SIGNATURE Francis X. Carmody		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Carmody		22d. ADDRESS 3201 N. Charles St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) entombment		23b. DATE THEREOF 11/2/67	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		25a. REC'D BY REGISTRAR NOV 9 1967	
ADDRESS 6500 York Road		25b. REGISTRAR'S SIGNATURE Charles Judge	
Balto. Md. 21212			

2000

2544

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13545

13549

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 15 <u>15 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chromemine Road</u>			d. STREET ADDRESS <u>Chromemine Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>VIRGINIA</u> Last <u>MEEKINS</u>			4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10, 1897</u>		9. AGE (In years last birthday) <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ellicott City, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Joseph E. Harmon</u>		
14. MOTHER'S MAIDEN NAME <u>Ethel L. Morris</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Mrs. Evelyn Sibley</u> Address <u>Chromemine Rd. Reisterstown, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphoma - abdominal</u> 2021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)			20g. (County)		20h. (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 15</u> , 19 <u>67</u> , to <u>October 27</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>October 27</u> , 19 <u>67</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>C. E. McWilliams</u>			22b. DATE SIGNED <u>10-29-67</u>		22c. PHYSICIAN'S NAME (Type) <u>C. E. McWilliams, M.D.</u>
22d. ADDRESS <u>Reisterstown Maryland</u>			22e. MED. DIRECTOR <input checked="" type="checkbox"/> MED. STAFF <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 30, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Stone Chapel Cemetery</u>	
23d. LOCATION (City or town) <u>Pikesville, Md.</u>		23e. (County)		23f. (State)	
24. FUNERAL DIRECTOR <u>H. J. Eckhardt</u>			ADDRESS <u>Owings Mills, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>
25b. REGISTRAR'S SIGNATURE			DATE <u>OCT 31 1967</u>		

1941

CERTIFICATE OF DEATH

202



[Faint, mostly illegible text, likely a form or record, possibly containing names and dates.]

[Handwritten signature or initials at the bottom right.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>	
c. LENGTH OF STAY in 1b <u>2 days</u>		d. STREET ADDRESS <u>3711 Vega Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bald County General Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nelen</u> Middle <u>B</u> Last <u>Melville</u>		4. DATE OF DEATH Month <u>10</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/4/91</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. S. Underwood</u>		14. MOTHER'S MAIDEN NAME <u>Emma Nutman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>320-48-9978-J71</u>	
17. INFORMANT <u>Richard H. Melville</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe coronary atherosclerosis-Thrombosis AT CORONARY</u> DUE TO (b) <u>OLD myocardial infarcts (2), left ventr+IVS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Myocardial-coronary insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal Aspiration of Gastric contents into respiratory tree</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-29</u> 19 <u>67</u> , to <u>10-29</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-29</u> 19 <u>67</u> and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Rolando A. Madamba</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>10-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROLANDO A. MADAMBA</u>		22d. ADDRESS <u>Bald Co Gen Hosp</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/1/67</u>	
23c. NAME OF CEMETERY OR CREMATOR <u>Druid Ridge</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Young Byers, Funeral Chapel</u>		25. REC'D BY REGISTRAR <u>NOV 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

3420

21-12-1951, (2) 1951-1952, 1953-1954, 1955-1956, 1957-1958, 1959-1960, 1961-1962, 1963-1964, 1965-1966, 1967-1968, 1969-1970, 1971-1972, 1973-1974, 1975-1976, 1977-1978, 1979-1980, 1981-1982, 1983-1984, 1985-1986, 1987-1988, 1989-1990, 1991-1992, 1993-1994, 1995-1996, 1997-1998, 1999-2000, 2001-2002, 2003-2004, 2005-2006, 2007-2008, 2009-2010, 2011-2012, 2013-2014, 2015-2016, 2017-2018, 2019-2020, 2021-2022, 2023-2024, 2025-2026, 2027-2028, 2029-2030, 2031-2032, 2033-2034, 2035-2036, 2037-2038, 2039-2040, 2041-2042, 2043-2044, 2045-2046, 2047-2048, 2049-2050, 2051-2052, 2053-2054, 2055-2056, 2057-2058, 2059-2060, 2061-2062, 2063-2064, 2065-2066, 2067-2068, 2069-2070, 2071-2072, 2073-2074, 2075-2076, 2077-2078, 2079-2080, 2081-2082, 2083-2084, 2085-2086, 2087-2088, 2089-2090, 2091-2092, 2093-2094, 2095-2096, 2097-2098, 2099-2100, 2101-2102, 2103-2104, 2105-2106, 2107-2108, 2109-2110, 2111-2112, 2113-2114, 2115-2116, 2117-2118, 2119-2120, 2121-2122, 2123-2124, 2125-2126, 2127-2128, 2129-2130, 2131-2132, 2133-2134, 2135-2136, 2137-2138, 2139-2140, 2141-2142, 2143-2144, 2145-2146, 2147-2148, 2149-2150, 2151-2152, 2153-2154, 2155-2156, 2157-2158, 2159-2160, 2161-2162, 2163-2164, 2165-2166, 2167-2168, 2169-2170, 2171-2172, 2173-2174, 2175-2176, 2177-2178, 2179-2180, 2181-2182, 2183-2184, 2185-2186, 2187-2188, 2189-2190, 2191-2192, 2193-2194, 2195-2196, 2197-2198, 2199-2200, 2201-2202, 2203-2204, 2205-2206, 2207-2208, 2209-2210, 2211-2212, 2213-2214, 2215-2216, 2217-2218, 2219-2220, 2221-2222, 2223-2224, 2225-2226, 2227-2228, 2229-2230, 2231-2232, 2233-2234, 2235-2236, 2237-2238, 2239-2240, 2241-2242, 2243-2244, 2245-2246, 2247-2248, 2249-2250, 2251-2252, 2253-2254, 2255-2256, 2257-2258, 2259-2260, 2261-2262, 2263-2264, 2265-2266, 2267-2268, 2269-2270, 2271-2272, 2273-2274, 2275-2276, 2277-2278, 2279-2280, 2281-2282, 2283-2284, 2285-2286, 2287-2288, 2289-2290, 2291-2292, 2293-2294, 2295-2296, 2297-2298, 2299-2300, 2301-2302, 2303-2304, 2305-2306, 2307-2308, 2309-2310, 2311-2312, 2313-2314, 2315-2316, 2317-2318, 2319-2320, 2321-2322, 2323-2324, 2325-2326, 2327-2328, 2329-2330, 2331-2332, 2333-2334, 2335-2336, 2337-2338, 2339-2340, 2341-2342, 2343-2344, 2345-2346, 2347-2348, 2349-2350, 2351-2352, 2353-2354, 2355-2356, 2357-2358, 2359-2360, 2361-2362, 2363-2364, 2365-2366, 2367-2368, 2369-2370, 2371-2372, 2373-2374, 2375-2376, 2377-2378, 2379-2380, 2381-2382, 2383-2384, 2385-2386, 2387-2388, 2389-2390, 2391-2392, 2393-2394, 2395-2396, 2397-2398, 2399-2400, 2401-2402, 2403-2404, 2405-2406, 2407-2408, 2409-2410, 2411-2412, 2413-2414, 2415-2416, 2417-2418, 2419-2420, 2421-2422, 2423-2424, 2425-2426, 2427-2428, 2429-2430, 2431-2432, 2433-2434, 2435-2436, 2437-2438, 2439-2440, 2441-2442, 2443-2444, 2445-2446, 2447-2448, 2449-2450, 2451-2452, 2453-2454, 2455-2456, 2457-2458, 2459-2460, 2461-2462, 2463-2464, 2465-2466, 2467-2468, 2469-2470, 2471-2472, 2473-2474, 2475-2476, 2477-2478, 2479-2480, 2481-2482, 2483-2484, 2485-2486, 2487-2488, 2489-2490, 2491-2492, 2493-2494, 2495-2496, 2497-2498, 2499-2500, 2501-2502, 2503-2504, 2505-2506, 2507-2508, 2509-2510, 2511-2512, 2513-2514, 2515-2516, 2517-2518, 2519-2520, 2521-2522, 2523-2524, 2525-2526, 2527-2528, 2529-2530, 2531-2532, 2533-2534, 2535-2536, 2537-2538, 2539-2540, 2541-2542, 2543-2544, 2545-2546, 2547-2548, 2549-2550, 2551-2552, 2553-2554, 2555-2556, 2557-2558, 2559-2560, 2561-2562, 2563-2564, 2565-2566, 2567-2568, 2569-2570, 2571-2572, 2573-2574, 2575-2576, 2577-2578, 2579-2580, 2581-2582, 2583-2584, 2585-2586, 2587-2588, 2589-2590, 2591-2592, 2593-2594, 2595-2596, 2597-2598, 2599-2600, 2601-2602, 2603-2604, 2605-2606, 2607-2608, 2609-2610, 2611-2612, 2613-2614, 2615-2616, 2617-2618, 2619-2620, 2621-2622, 2623-2624, 2625-2626, 2627-2628, 2629-2630, 2631-2632, 2633-2634, 2635-2636, 2637-2638, 2639-2640, 2641-2642, 2643-2644, 2645-2646, 2647-2648, 2649-2650, 2651-2652, 2653-2654, 2655-2656, 2657-2658, 2659-2660, 2661-2662, 2663-2664, 2665-2666, 2667-2668, 2669-2670, 2671-2672, 2673-2674, 2675-2676, 2677-2678, 2679-2680, 2681-2682, 2683-2684, 2685-2686, 2687-2688, 2689-2690, 2691-2692

- × Transverse vibration of control outputs into feedback of tree

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13547 CERTIFICATE OF DEATH 13551											
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WOODLAWN c. LENGTH OF STAY IN 1b 45 YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6721 WINDSOR MILL RD.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WOODLAWN d. STREET ADDRESS 6721 WINDSOR MILL RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First FREDERICK Middle AUGUST Last METT						4. DATE OF DEATH Month 10 Day 4 Year 1967					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC 29, 1889		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR: Months 10 Days 4 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner of Mining Co.				10b. KIND OF BUSINESS OR INDUSTRY owner.				11. BIRTHPLACE (County & State, or foreign country) Balto, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FREDERICK AUGUST METT						14. MOTHER'S MAIDEN NAME -					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YU						16. SOCIAL SECURITY NO. WORLD WART 216-03-8468		17. INFORMANT Miss Frances Mett Address BALTO. 21207 Md. 6721 WINDSOR MILL RD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 523.2 DEGENERATIVE HEART DISEASE DUE TO ARRESTICOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) hypertension; arteriosclerosis; previous DUE TO (c) 10 years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from MAY 10, 1956 to OCT. 4, 1967 , that (I) (we) last saw the deceased alive on OCT. 3, 1967 , and that death occurred at 12:02 PM , from the causes and on the date stated above.											
22a. SIGNATURE Edwin L. Pierpont						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D.						22d. ADDRESS 8704 LIBERTY RD. BALTO. 21207 Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-7-67		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY - BALTO - Md -				23d. LOCATION (city, town or county) (State)			
24. FUNERAL DIRECTOR Ellsworth Armacost ADDRESS 4600 Liberty Heights Ave.						25a. REC'D BY REGISTRAR 1967 DATE OCT 5		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

1000

STATE OF TEXAS

1000

1000

6 130

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13548

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13552

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6 Lombardy Ct.		d. STREET ADDRESS 6 Lombardy Ct.	
3. NAME OF DECEASED (Type or print) First CHARLES Middle PARKER Last MICHEL		4. DATE OF DEATH Month 10 Day 4 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1948
9. AGE (In years last birthday) yrs. 19		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) College Student		10b. KIND OF BUSINESS OR INDUSTRY In School	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry O. Michel		14. MOTHER'S MAIDEN NAME Mary Parker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of the chest DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject shot himself in the chest	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ? p.m. ? 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Towson Balto. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		22. DATE SIGNED October 4, 1967	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) October 4, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF Oct. 5, 1967	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		25a. REC'D BY REGISTRAR OCT 9 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13553

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson			c. LENGTH OF STAY in lb 520 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital				d. STREET ADDRESS 321 E. CHURCH ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT OTIS MILLBERRY				4. DATE OF DEATH 10/18/67			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-7-08		9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY MILLBERRY				14. MOTHER'S MAIDEN NAME LIZZIE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-10-0363		17. INFORMANT Address Records at Mt. Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 0021 FAR ADVANCED PULMONARY DUE TO TUBERCULOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO COR PULMONALE (c)						INTERVAL BETWEEN ONSET AND DEATH TWO YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-29 , 1966, to 10-18 , 1967, that (I) (we) last saw the deceased alive on 10-18 , 1967, and that death occurred at 10:55 PM , from causes and on the date stated above.							
22a. SIGNATURE William Newcomer				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) William Newcomer, M.D.	
22d. ADDRESS Mount Wilson, Maryland				22e. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-23-67		23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW		23d. LOCATION (City or Town) (County) (State) FREDERICK Fred Md	
24. FUNERAL DIRECTOR Charles H. H. Frederick				25a. REC'D BY REGISTRAR DATE 10 OCT 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13549

13554

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN TB 12 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3520 Louth Road		d. STREET ADDRESS 3520 Louth Road	
3. NAME OF DECEASED (Type or print) First David Middle W. Last Miller Sr.		4. DATE OF DEATH Month October Day 3 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1906
9. AGE (In years lost birthday) 60 yrs.		IF UNDER 1 YEAR Months 03 Days 1 IF UNDER 24 HRS. Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Slusher		10b. KIND OF BUSINESS OR INDUSTRY American Standard	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bert Miller		14. MOTHER'S MAIDEN NAME Susie Niswonger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218 05 2404	
17. INFORMANT (Wife) Mrs. Dorothy Miller, 3520 Louth Rd. Dundalk,		Address Md. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO A-S-C-V-Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Hypertensive C.V. Disease (b) 3 yrs (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Morningside Rd. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Dundalk, Md. 21222 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/3/67 Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/67	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. Cem.		23d. LOCATION (City or Town) (County) (State) Dorsey, Maryland	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR DATE OCT 9 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G394 10/27/67 bh

CERTIFICATE OF DEATH

13550

13555

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. LENGTH OF STAY IN TB <u>LIFE</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2812 Taylor Ave</u>		d. STREET ADDRESS <u>2812 Taylor Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>F</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 27, 1889</u>
9. AGE (In years and birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>24</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICE MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Police Dept</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas M Miller</u>		14. MOTHER'S MAIDEN NAME <u>ANNA B Rau</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-40-7229</u>	
17. INFORMANT <u>Caroline Miller</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal labor pneumonia</u> 4201 DUE TO (b) <u>Left hemiplegia</u> DUE TO (c) <u>Cardio-vascular and disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>7 days</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary occlusion - 1945</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1963 to Oct. 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct. 21, 1967</u> , and that death occurred at <u>10:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>C. M. Bacon</u>		22b. DATE SIGNED <u>10/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. M. BACON</u>		22d. ADDRESS <u>2810 Taylor Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>OCT 25, 1967</u>	<u>Moreland Memorial</u>	<u>BALTO MD.</u>
24. FUNERAL DIRECTOR <u>Chas. F. Evans & Son</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>8802 Hartford Rd</u>		DATE <u>OCT 24 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13551

CERTIFICATE OF DEATH

13556

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>334 Radnor Rd</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balt. Medical Center</u>			d. STREET ADDRESS <u>334 Radnor Rd</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stanley Joseph Miller</u>			4. DATE OF DEATH Month Day Year <u>10 28 19 67</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-23</u>	9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Scully Rubber Mfg.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>John Miller</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WW II</u>			16. SOCIAL SECURITY NO. <u>216-18-0032</u>		17. INFORMANT <u>Patient's chart</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma sigmoid colon</u> DUE TO (b) <u>Metastases to lung, liver and bone.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 23, 1967</u> , to <u>Oct 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 28, 1967</u> , and that death occurred at <u>240 P</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>M. Isabelle MacGregor</u>			22b. DATE SIGNED <u>10-28-67</u>		22c. PHYSICIAN'S NAME (Type) <u>DR. STUART SUNDAY</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>11-2-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEMETERY</u>
24. FUNERAL DIRECTOR <u>JOHN M WEBER & SONS INC 4015 CHESTER ST.</u>			25a. REC'D BY REGISTRAR <u>DATE OCT 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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CENTRAL OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
13552 CERTIFICATE OF DEATH 13557										
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ann Arundel</u>			c. LENGTH OF STAY IN 1b <u>20 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>031</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6411 Barbours Rd</u>					d. STREET ADDRESS <u>6411 Barbours Rd</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Woodrow D. Miller</u>			First Middle Last		4. DATE OF DEATH <u>Oct 12 1967</u>		Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 15 1920</u>		9. AGE (In years last birthday) <u>47</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship Building</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>David R. Miller</u>					14. MOTHER'S MAIDEN NAME <u>Winnie M Davis</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>219 01 2032</u>		17. INFORMANT <u>Helen T Miller</u> Address <u>6411 Barbours Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>1533</u> DUE TO <u>Carcinoma of sigmoid colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>10 months</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>8/4/</u> , 19 <u>67</u> , to <u>10/12/</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>September 6</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> M., from the causes and on the date stated above.										
22a. SIGNATURE <u>L. Kemper Owens</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Kemper Owens, M.D.</u>					22d. ADDRESS <u>Six East Read Street 21202</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Oct 14 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Uniontown Lutheran</u>		23d. LOCATION (City, town or county) (State) <u>Uniontown Carroll Co Md</u>			
24. FUNERAL DIRECTOR <u>Burgess Funeral Home</u>					ADDRESS <u>Baltimore Md</u>		25a. REC'D BY REGISTRAR <u>OCT 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	

CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *Jan 15 1904*

5. Place of death: *Home*

6. Cause of death: *Heart Disease*

7. Signature of physician: *J. H. Smith*

8. Signature of registrar: *W. B. Jones*

9. Signature of undertaker: *W. B. Jones*

10. Signature of coroner: *W. B. Jones*

11. Signature of jury: *W. B. Jones*

12. Signature of witnesses: *W. B. Jones*

13. Signature of family: *W. B. Jones*

14. Signature of neighbors: *W. B. Jones*

15. Signature of friends: *W. B. Jones*

16. Signature of others: *W. B. Jones*

17. Signature of others: *W. B. Jones*

18. Signature of others: *W. B. Jones*

19. Signature of others: *W. B. Jones*

20. Signature of others: *W. B. Jones*

THE STATE DEPARTMENT OF HEALTH
LABORATORY DIVISION
1904

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *Jan 15 1904*

5. Place of death: *Home*

6. Cause of death: *Heart Disease*

7. Signature of physician: *J. H. Smith*

8. Signature of registrar: *W. B. Jones*

9. Signature of undertaker: *W. B. Jones*

10. Signature of coroner: *W. B. Jones*

11. Signature of jury: *W. B. Jones*

12. Signature of witnesses: *W. B. Jones*

13. Signature of family: *W. B. Jones*

14. Signature of neighbors: *W. B. Jones*

15. Signature of friends: *W. B. Jones*

16. Signature of others: *W. B. Jones*

17. Signature of others: *W. B. Jones*

18. Signature of others: *W. B. Jones*

19. Signature of others: *W. B. Jones*

20. Signature of others: *W. B. Jones*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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13553

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13559

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 21236 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21236 d. STREET ADDRESS 3802 Joppa Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edna Jane MOON		4. DATE OF DEATH Month Day Year October 5, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1890
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME E.D. Owen Davis, Sr.	
14. MOTHER'S MAIDEN NAME Unk.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 217246934		17. INFORMANT Address Mr. Leroy Burkhear, Sr. 8 W. Elm Ave Balto 6 Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of colon with metatasis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that no (this hospital) attended the deceased from 10/4/ , 19 67 , to 10/5/ , 1967, that no (we) last saw the deceased alive on 10/5/ , 19 67 , and that death occurred at 1:21 PM , from causes on and on the date stated above.			
22a. SIGNATURE Lawrence T. Misanik, M.D.		22b. DATE SIGNED October 5, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence T. Misanik, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/9/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore Balto. Md.
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd.		25a. REC'D BY REGISTRAR DATE OCT 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

100

a b c d

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13554

13580

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home				d. STREET ADDRESS 3316 Kenyon Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ELVA F. MOONEY				4. DATE OF DEATH Month October Day 28 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1887		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Warnbach				14. MOTHER'S MAIDEN NAME Letitia Shannon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-22-4806 B		17. INFORMANT Address Mrs. Katherine Loeffler 408 S. Bouldin St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Hypertensive heart disease DUE TO (c) Diabetes mellitus, moderate						INTERVAL BETWEEN ONSET AND DEATH 15 years 10 years 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital telangiectasia multiple epistaxis.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from July , 19 46 , to 28 Oct. , 19 67 , that (I) (we) last saw the deceased alive on 28 Oct. , 19 67 , and that death occurred on 28 Oct. , 19 67 , at 7:30 P.M., from causes and on the date stated above.							
22a. SIGNATURE Robert Z. Berry				22b. DATE SIGNED 29 Oct. 1967		22c. PHYSICIAN'S NAME (Type) Robert Z. Berry	
22d. ADDRESS Medical Arts Building							
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF Oct. 31, 1967		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home 4210 Belair Road.				25a. REC'D BY REGISTRAR NOV 2 1967		25b. REGISTRAR'S SIGNATURE f Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATEMENT OF WITNESSES

100-100000

100-100000

Witness: [Name] [Address] [City] [State] [Zip]
[Signature] [Date]

On [Date] at [Location] [Name] [Address] [City] [State] [Zip]
[Signature] [Date]

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13555

CERTIFICATE OF DEATH

13561

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			c. LENGTH OF STAY IN lb 39 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital				d. STREET ADDRESS 31 S. Carey St. Balto, Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alfred		First B		Middle Moore		Last	
4. DATE OF DEATH 10		Month 21		Day 19		Year 67	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-15-15	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A				13. FATHER'S NAME Alfred B. Moore (deceased)			
14. MOTHER'S MAIDEN NAME Elizabeth Sheeren				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16. SOCIAL SECURITY NO. none				17. INFORMANT Rosewood Records, Owings Mills, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 753.1 DUE TO Aspiration of Food Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral defect, congenital (c) 28 yrs.						INTERVAL BETWEEN ONSET AND DEATH Terminal Terminal	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aspiration during feeding			
20c. TIME OF INJURY Month, Day, Year 8:35 a.m. 21 Oct 1967		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rosewood Hosp. Owings Mills Balto. Md.		20f. (City or town) (County) (State)	
21. I certify that (if this hospital attended the deceased from 29 Aug 1967 to 21 Oct 1967 , that (I) (we) last saw the deceased alive on 20 Oct 1967 , and that death occurred at 8:50 A.M. from causes and on the date stated above.							
22a. SIGNATURE Richard A. Jones				22b. DATE SIGNED 21 Oct 67		22c. PHYSICIAN'S NAME (Type) Richard A. Jones	
22d. ADDRESS Rosewood State Hosp.				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/24/67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) Baltimore Md	
24. FUNERAL DIRECTOR Leonard J Ruck Inc 5305 Harford Rd				25a. REC'D BY REGISTRAR OCT 23 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13001

Asphyxia
of food

20 July 1968

George Stet 4009

20 July 1968
Richard A. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13562

13556

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville-Timonium 21093		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville-Timonium 21093	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1019 West Seminary Avenue			d. STREET ADDRESS 1019 West Seminary Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) SARA K. MORAN			4. DATE OF DEATH OCTOBER 11, 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1893	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		10b. KIND OF BUSINESS OR INDUSTRY Dept. Stores		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Christian Kogler			14. MOTHER'S MAIEN NAME Margaret Shuster		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-07-9523A		17. INFORMANT Address Mrs. Eleanor Baum, Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO (b) Carcinoma of Uterus DUE TO (c) 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH 2 months 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 7 October 1967 , to 10/11, 1967 , that (I) <input checked="" type="checkbox"/> lost the deceased alive on 10/9, 1967 , and that death occurred at 10:30 AM , from causes on and on the date stated above.					
22a. SIGNATURE Charles F. O'Donnell M.D.			22b. DATE SIGNED 10-11-67		
22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell			22d. ADDRESS 7501 York Rd 21204		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Oct. 14, 1967		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson,			1050 YORK Road Towson, Maryland 21204		25a. REC'D BY REGISTRAR OCT 13 1967
			25b. REGISTRAR'S SIGNATURE [Signature]		

1300

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

STATEMENT OF WITNESSES

1300



STATEMENT OF WITNESSES

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UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (9)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13557

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13563

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Unknown b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Unknown Woodlawn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6300 block Liberty Rd.		d. STREET ADDRESS 62231 Liberty Hights Terraces	
3. NAME OF DECEASED (Type or print) LENORA MORRIS		4. DATE OF DEATH Month October Day 31 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16-1967/1897
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Bowen		14. MOTHER'S MAIDEN NAME Dona Francis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John Morris		Address Rt. 1, Box 147B, Pasadena, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 8124 IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject was pedestrian struck by auto	
20c. TIME OF INJURY Month, Day, Year 9:30 p.m. 10 31 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Baltimore Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson M.D.		22. DATE SIGNED November 1, 1967	
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Freeland, Balto. Co. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11/4-1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion	23d. LOCATION (City or Town) (County) (State) Freeland, Balto. Co. Md.
24. FUNERAL DIRECTOR Frank H. Leitz 814 W 36 St Baltimore		25a. REC'D BY REGISTRAR DATE NOV 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

13558

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13561

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b about 2 wks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 418 Virginia Avenue	
3. NAME OF DECEASED (Type or print) First SHERMAN Middle W. Last MORRIS		4. DATE OF DEATH Month October Day 14 Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/15/20
9. AGE (In years lost birthday) 46 46 yrs.		10. IF UNDER 1 YEAR Months 46 Days 46 Hours 46 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		10b. KIND OF BUSINESS OR INDUSTRY Furniture Factory	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gas. W. Morris		14. MOTHER'S MAIDEN NAME Lianna Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO. W.W. H 172-12-5565	
17. INFORMANT alice morris		Address 118 Lincoln Ave. Lutherville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atlanto-occipital disarticulation with brainstem injury Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) XXXXX (c) injury		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by auto	
20c. TIME OF INJURY Month, Day, Year Hour 7:55 p.m. 10-14 19 67		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) Towson Baltimore Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		22. DATE SIGNED October 14, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/18/67	
23c. NAME OF CEMETERY OR CREMATORY Balto. National		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR Wm. J. Chatman		25a. REC'D BY REGISTRAR OCT 17 1967	
Address 1701 McCallum St. Balto. Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Baltimore		c. LENGTH OF STAY IN 1b Baltimore 21212	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Armacost Nursing Home		d. STREET ADDRESS 6100 Edlyne Road	
3. NAME OF DECEASED (Type or print) First Middle Last PATRICK H. MORRISON		4. DATE OF DEATH Month Day Year October 18, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/30/1907
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Blaine Morrison		14. MOTHER'S MAIDEN NAME Catherine Flatley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214 18 7677	
17. INFORMANT Mrs. Maurice S. Bozel-		Address 6100 Edlyne	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung with DUE TO Cerebral Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 16, 1967 to Oct 18, 1967 , that (I) (we) last saw the deceased alive on Oct 13, 1967 , and that death occurred at 4:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE William H. Fusting		22b. DATE SIGNED 10-19-67	
22c. PHYSICIAN'S NAME (Type) William H. Fusting		22d. ADDRESS 4230 Loch Raven Blvd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/21/67	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem.	23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR OCT 19 1967	
25b. REGISTRAR'S SIGNATURE John R. Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13550

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13550

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Merridale c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 635 Plymouth Road				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Merridale d. STREET ADDRESS 635 Plymouth Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Joseph Murphy				4. DATE OF DEATH Oct. 15, 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 6, 1896	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Railway Express		11. BIRTHPLACE (County & State, or foreign country) BaltoMd.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME James N. Murphy				14. MOTHER'S MAIDEN NAME Rose McKeever			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 714-03-4100		17. INFORMANT Address Mrs. Matilda L. Murphy 635 Plymouth Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Coronary Atherosclerosis DUE TO (c) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 1 day 23 hr 5 hr?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-15-1966 , to 10-15-1967 , that (I) (we) last saw the deceased alive on 10-17-1967 , and that death occurred at 11 P. M, from the causes and on the date stated above.							
22a. SIGNATURE Wilmer K. Gallagher						22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, Sr.						22d. ADDRESS 6209 Frederick Ave.,	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-1967		23c. NAME OF CEMETERY OR CREMATORY Balto. National		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR ADDRESS G. Howard Strong 3207 W. North Ave.,				25a. REC'D BY REGISTRAR OCT 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1935

Baltimore

Baltimore

637 7th Street

637 7th Street

James

Joseph

Joseph

John

John

John, 1892

VI

John

John, 1892

James M. Murphy

James M. Murphy

VI-1-100 Mrs. Joseph M. Murphy 637 7th Street

John M. Murphy, 1892, 637 7th Street

John M. Murphy, 1892, 637 7th Street

John M. Murphy, 1892, 637 7th Street

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13561

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13567

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 35 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 705 Wise Ave.		d. STREET ADDRESS 705 Wise Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last William J. Myatt		4. DATE OF DEATH Month Day Year October 10 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1896
9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co. Tennessee	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John M. Myatt		14. MOTHER'S MAIDEN NAME Tina Yates	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-5355	
17. INFORMANT (Wife) Mrs. Mary C. Myatt, 705 Wise Ave. Dundalk.		Address Md. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 A-S-C-V-Disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis M.D.		22. DATE SIGNED 10/11/67	
EXAMINER'S NAME (Type) Melvin B. Davis		23. LOCATION (City or Town) (County) (State) Dorsey, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10/11/67	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. Cem.	23d. LOCATION (City or Town) (County) (State) Dorsey, Md.
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR OCT 13 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

1956

Michigan

Michigan

105 West Ave.

William

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1956

Sept. 29, 1956

White

Married

John A. Davis

No

105 West Ave.

(Silo)

105 West Ave., Detroit, Mich. 48202

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105 West Ave.

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105 West Ave., Detroit, Mich.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13562

CERTIFICATE OF DEATH

13568

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 4028 Klausmier Ave. Road 21236		03-1	
3. NAME OF DECEASED (Type or print) First Middle Last Ella T. NEISER				4. DATE OF DEATH Month Day Year October 31, 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 11, 1895	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Strong				14. MOTHER'S MAIDEN NAME Virginia R. Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-26-5802		17. INFORMANT Address Charles H. Neiser 4028 Klausmier Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4330 Cardio-respiratory arrest DUE TO (b) Cerebral hemorrhage DUE TO (c) Hemiplegia, left.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/29/ , 19 67 , to 10/31/ , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/31/ 19 67 , and that death occurred at 2:10 P. from causes and on the date stated above.							
22a. SIGNATURE Gualberto C. Gokim, Jr. M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED October 31, 1967	
22c. PHYSICIAN'S NAME (Type) Gualberto C. Gokim, Jr., M.D.				22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-3-1967		23c. NAME OF CEMETERY OR CREMATORY Bel Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Bel Air Harford Md.	
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road				25a. REC'D BY REGISTRAR DATE NOV 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13563

CERTIFICATE OF DEATH

13569

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 1653 Nature Rd. 21204	
3. NAME OF DECEASED (Type or print) First JOHN Middle L. Last NEUHAUS SR.		4. DATE OF DEATH Month October Day 26 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1899
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 03 Days 1 Hours 00 Min. 00	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		11b. KIND OF BUSINESS OR INDUSTRY Marine	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John G. Neuhaus		14. MOTHER'S MAIDEN NAME Mary A. Hauzzenzol	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215 05 7584	
17. INFORMANT Mrs. Mary Neuhaus		Address 1653 Nature Rd. 21204	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia, right cerebrum DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral arteriosclerosis DUE TO (c) Diabetes mellitus.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (s) (this hospital) attended the deceased from Oct. 25 , 1967, to Oct. 26 , 1967, that (s) (we) last saw the deceased alive on Oct. 26 , 1967, and that death occurred at 8:30 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence F. Misanik</i> M.D.		22b. DATE SIGNED October 27, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-30-67	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland. Balto.
24. FUNERAL DIRECTOR Wm.E. Johnson, 8521 Loch Raven Blvd. 21204		25a. REC'D BY REGISTRAR NOV 1 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13564

13570

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>NEW YORK</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW YORK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxliegh Nursing Home</u>		d. STREET ADDRESS <u>110 BENNETT AVENUE, N.Y.</u> <u>NEW YORK</u>	
3. NAME OF DECEASED (Type or print) First <u>Amelia</u> Middle <u>Nitzburg</u> Last <u>Nitzburg</u>		4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	9. AGE (In years last birthday) yrs. <u>77</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ABRAHAM MEVERSON</u>		14. MOTHER'S MAIDEN NAME <u>SARAH HOROWITZ</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>065-30-6993</u>	
17. INFORMANT <u>115 W. 79th St. NEW YORK, N.Y.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Art Disease</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Atherosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>66</u> to <u>Oct 9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 9</u> , 19 <u>67</u> , and that death occurred at <u>6 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leonard Rotz</u>		22b. DATE SIGNED <u>10/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEONARD ROTZ, MD</u>		22d. ADDRESS <u>1101 42nd Ave Baltimore 21208</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON</u>	23d. LOCATION (City or Town) (County) (State) <u>RIDGEWOOD, NEW YORK</u>
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD</u>		25a. REC'D BY REGISTRAR <u>OCT 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13565

CERTIFICATE OF DEATH

13571

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2153 Vailthorn Road #21220 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles W. NOFSKER		4. DATE OF DEATH Month October Day 3 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1941
9. AGE (In years last birthday) 26 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Martin Company	
11. BIRTHPLACE (County & State, or foreign country) Altoona, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel B. Nofsker		14. MOTHER'S MAIDEN NAME Helen Wysong	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Hospital Records-St. Joseph	
17. INFORMANT Hospital Records-St. Joseph		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis 576X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intestinal familial polyposis with malignant degeneration.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 1 (this hospital) attended the deceased from September 8, 19 67 , to October 3, 1967 , that 1 (we) last saw the deceased alive on October 3, 19 67 , and that death occurred at 1:20AM , from causes on and on the date stated above.			
22a. SIGNATURE Reynaldo Orjuela-Gomez, M.D.		22b. DATE SIGNED October 3, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/67	
23c. NAME OF CEMETERY OR CREMATORY Creson Valley Cem.		23d. LOCATION (City or Town) (County) (State) Blair Co., Pa.	
24. FUNERAL HOME Mitchell Wiedefeld Home-6500 York Rd-21212		25. REC'D BY REGISTRAR OCT 4 1967	
25a. REGISTRAR'S SIGNATURE Barefoot Funeral Home, East Freedom, Pa.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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13566

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13572

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GARRISON		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 30-4			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FOXLEIGH NURSING HOME				d. STREET ADDRESS 603 S. Decker Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FELIX OR FELICE NOTARANGELO				4. DATE OF DEATH Month 10 Day 31 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/9/83	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER			10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (County & State, or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME THEODORE NOTARANGELO				14. MOTHER'S MAIDEN NAME MARY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-07-1267A		17. INFORMANT NICHOLAS NOTARANGE Address 5606 SAGRA RD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 10-26 , 19 67 , to 10-31 , 19 67 , that (1) (we) last saw the deceased alive on 10-30 19 67 , and that death occurred at 8:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE David D. Miller				22b. DATE SIGNED 10-31-67		22c. PHYSICIAN'S NAME (Type) David D. Miller	
22d. ADDRESS Crason Rd - Owings Mills Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/4/69		23c. NAME OF CEMETERY OR CREMATORY HOLUREDEEMER		23d. LOCATION (City, town or county) (State) BALTO MD.	
23e. FUNERAL DIRECTOR Frank Delehove		23f. ADDRESS 322 S. HIGH ST		25a. REC'D BY REGISTRAR NOV 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13567									
13573									
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE c. LENGTH OF STAY IN 1b BALTIMORE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DULANY TOWSON NURSING HOME					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTO c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 6634 SANZO ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) SAMUEL I. NOVICK					4. DATE OF DEATH Month OCT Day 2 Year 1967				
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/4/1890		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER		10b. KIND OF BUSINESS OR INDUSTRY PAINT CO		11. BIRTHPLACE (County & State, or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME LOUIS					14. MOTHER'S MAIDEN NAME LILLIAN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. 02-07-5146		17. INFORMANT Wife Address Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis									INTERVAL BETWEEN ONSET AND DEATH 2 WKS 2 yrs 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Wernicke Traub Reaction Bronchi Pneumonia									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) BALTO		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 15, 1965 , to 10-2-1967 , that (I) (we) last saw the deceased alive on 9-30-1967 , and that death occurred at 5 P.M. , from the causes and on the date stated above.									
22a. SIGNATURE M. W. JACOBSON					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/3/67		
22c. PHYSICIAN'S NAME (Type) M. W. JACOBSON MD					22d. ADDRESS 6821 REISTERSTOWN RD BALTO MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 10/4/67		23c. NAME OF CEMETERY OR CREMATORY LODGE PARK		23d. LOCATION (City, town or county) BALTO		(State) MD	
24. FUNERAL DIRECTOR'S SIGNATURE Sylvan S Lewis & Son, Inc					25a. REC'D BY REGISTRAR DATE OCT 5 1967				
ADDRESS Garrison, Md					25b. REGISTRAR'S SIGNATURE Charles Judge				



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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13568

13574

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>		d. STREET ADDRESS <u>5715 Charlestowne</u>	
3. NAME OF DECEASED (Type or print) First <u>Dennis</u> Middle <u>E.</u> Last <u>O'Brien</u>		4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-1911</u>
9. AGE (In years lost birthday) <u>76</u>		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Employee Balto. City</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas O'Brien</u>		14. MOTHER'S MAIDEN NAME <u>Julia Shea</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>220-09-4850</u>	
17. INFORMANT <u>Edward O'Brien, 105 Sipple Ave.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Refractory anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>10 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>about</u> , 19 <u>60</u> , to <u>10-19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-19</u> , 19 <u>67</u> , and that death occurred at <u>9 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Lawrence M. Serra</u>		22b. DATE SIGNED <u>10-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lawrence M. Serra</u>		22d. ADDRESS <u>H E. Chase St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-23-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto., Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 23 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1937

CERTIFICATE OF DEATH

Thomas, John
250-23-450 - Thomas, John, 105 St. Louis Ave.
U.S.A.

John, 105

John, 105

10-23-45

John, 105

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13569

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13575

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. LENGTH OF STAY IN 1b Lansdowne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 255 Clyde Ave.		d. STREET ADDRESS 255 Clyde Ave. 21227	
3. NAME OF DECEASED (Type or print) First William Middle Clifford Last Oden		4. DATE OF DEATH Month 10 Day 22 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Se DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/33
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months 33 Days 33 Hours 33 Min.	IF UNDER 24 HRS. Hours 33 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Tolliver S. Oden, Sr.	
14. MOTHER'S MAIDEN NAME Ida - - - - -		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. Tolliver S. Oden, Sr., 255 Clyde Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation By Hanging 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James N. Frederick EXAMINER'S NAME (Type) Dr. James N. Frederick		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 1311 Francis Ave.	
22. DATE SIGNED 10/23/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/26/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR OCT 25 1967 DATE	
25b. REGISTRAR'S SIGNATURE John J. Judge			

10/15/57

10/15/57

MEMORANDUM FOR THE RECORD

TO :

FROM :

SUBJECT :

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

[illegible signature]

[illegible signature]

[illegible text]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

20 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD 10-10-67
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13570

CERTIFICATE OF DEATH

13576

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 3 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 328 Regester Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 328 Regester Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle J. O'Hara Last 4. DATE OF DEATH Month Oct. Day 29 Year 1967		5. SEX Male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 10, 1907 9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Clerk		10b. KIND OF BUSINESS OR INDUSTRY Steel Co. 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. O'Hara		14. MOTHER'S MAIDEN NAME Anna Bosson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-01-7921 17. INFORMANT Address Mrs. Josephine O'Hara same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Posterior Fossa Brain Tumor - probably DUE TO Metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Lung. (Metastatic July 67) DUE TO (c) 163X		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 1967, to August , 1967, that (I) (we) last saw the deceased alive on Aug-2 1967, and that death occurred at 2 P.M. from causes and on the date stated above.			
22a. SIGNATURE W. Richard Ferguson		22b. DATE SIGNED Oct. 30 - 67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 2, 1967	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		25a. REC'D BY REGISTRAR NOV 2 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS 1050 York Road 21204 Towson, MD 21204			

1307E

DEPARTMENT OF HEALTH

1307E

2-2-1981

Robertson, John
Cancer Research
Department of Health

63

63

Robertson, John

NOV 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13571

CERTIFICATE OF DEATH

13577

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>279 Chatsworth Ave.</i>		d. STREET ADDRESS <i>279 Chatsworth Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mary D. Owings</i>		4. DATE OF DEATH Month <i>October</i> Day <i>20</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 22, 1886</i>
9. AGE (In years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR Months <i>03</i> Days <i>1</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore City, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Rawlings</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Cook</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-54-5530</i>	
17. INFORMANT <i>Mrs. M. Dorothea Miller</i>		Address <i>Reisterstown, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO (b) <i>& V.A.D. cerebral degeneration</i> DUE TO (c) <i>terminal pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1-1-1930</i> to <i>10-20-1967</i> , that (I) (we) last saw the deceased alive on <i>10-19-1967</i> , and that death occurred at <i>12:30 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>James G. Saffell</i>		22b. DATE SIGNED <i>10-20-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>James G. Saffell</i>		22d. ADDRESS <i>Reisterstown, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 23, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>All Saints Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Reisterstown, Md.</i>	
24. FUNERAL DIRECTOR <i>J. F. Eline & Sons</i>		25a. REC'D BY REGISTRAR <i>Charles J. J...</i>	
ADDRESS <i>Reisterstown, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>	
DATE <i>OCT 23 1967</i>			

100-1

STATE OF MICHIGAN

100-1

100-1

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13572

CERTIFICATE OF DEATH

13578

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>Baltimore, Md 21215</u>	
3. NAME OF DECEASED (Type or print) <u>Alfred (Alfonso) Charles Palaski</u>		4. DATE OF DEATH <u>10 - 18 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-10</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Emerson Hotel</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Palaski</u>		14. MOTHER'S MAIDEN NAME <u>Julia Bernos</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-2817</u>	
17. INFORMANT <u>Angelina Palaski, 4512 Garden Dr.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> DUE TO <u>Maligancy, Rt. Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>To brain metastasis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-26-66</u> , 19 <u>66</u> , to <u>10-18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-18</u> , 19 <u>67</u> , and that death occurred at <u>6:25 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Jose M. de Leon</u>		22b. DATE SIGNED <u>10-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSE M. DE LEON, M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-21-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto., Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc., 5305 Harford Rd.</u>		25a. REC'D BY REGISTRAR <u>10-19-67</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1334

1334

Alfred (Alfred) Charles Black

Julia Thomas

SID-1-2017 Angelina Palamini, 1912 version 17.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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13573		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		13579	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 23yr5mth9dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1819 North Milton Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Lewis Last Parker		4. DATE OF DEATH Month October Day 24 Year 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1904	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 19 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) printer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME William Parker		14. MOTHER'S MAIDEN NAME Lydia Horst		12. CITIZEN OF WHAT COUNTRY? U. S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-1427		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular heart disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Arteriosclerosis, generalized DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lobar pneumonia, terminal; organism undetermined				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (X) (this hospital) attended the deceased from May 15, 1944 , to Oct. 24, 1967 , that (X) (we) last saw the deceased alive on Oct. 24, 1967 , and that death occurred at 3:15 M, from causes and on the date stated above.					
22a. SIGNATURE <i>Anthony J. Young M.D.</i>		22b. DATE SIGNED 10-25-67		22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.	
22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/28/67.		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE OCT 26 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>	

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DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13574

13580

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Randallstown, Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chapel Hill Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lillian I. Pearson</u>		4. DATE OF DEATH Month <u>October</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22, 1909</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>John</u>	
14. MOTHER'S MAIDEN NAME <u>Ella</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Delmas O. Pearson</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.A. of Pancreas & Metastases</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-22-1967</u> , to <u>10-23-1967</u> , that (I) (we) last saw the deceased alive on <u>10-23-1967</u> , and that death occurred at <u>10 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Cesar Valle Caverio</u>		22b. DATE SIGNED <u>10-24-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERO</u>		22d. ADDRESS <u>8629 Liberty Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE THEREOF <u>10/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. Maryland</u>
24. FUNERAL DIRECTOR <u>Witzke & Sons</u> ADDRESS <u>4101 Edmondson Ave. 21229</u>		25a. REC'D BY REGISTRAR <u>DATE 11 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13575

13581

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN lb <u>21 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>3500 Rosedale Rd</u> d. STREET ADDRESS <u>3500 Rosedale Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>George HARRIS Pendheton</u>		4. DATE OF DEATH <u>10 24 1967</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-29-01</u>		9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR Months Days Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Medical</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Annapolis, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George L. Pendheton</u>				14. MOTHER'S MAIDEN NAME <u>Clarina HARRIS</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					
16. SOCIAL SECURITY NO. <u>214-44-7119</u>				17. INFORMANT <u>Patient's CHART</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Post Pneumonecomy</u> (c) <u>carcinoma Right lung</u>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10-5-</u> , 19 <u>67</u> , to <u>10-24-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-24-</u> , 19 <u>67</u> , and that death occurred at <u>12:25 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>P. Chaudhuri</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <u>10-24-67</u>					
22c. PHYSICIAN'S NAME (Type) <u>P. CHAUDHURI</u>				22d. ADDRESS <u>Greater Baltimore Medical Center</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Annapolis Md. Anne Arundel.</u>			
24. FUNERAL DIRECTOR <u>Herbert E. Nutter-3035 W. North Ave.</u>				25a. REC'D BY REGISTRAR <u>OCT 27 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>					

No
 4-4-57
 Father's Chart
 Harris
 Annapolis, Md
 USA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

13579 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13582

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MASS.</u> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>			c. LENGTH OF STAY IN 1b <u>14</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NARRAGANSETT AVE 58.3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MASONIC Homes BonnieBlink</u>				d. STREET ADDRESS <u>Pittsfield</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>E</u> Last <u>Perine</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>1</u> Year <u>1967</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/9/1875</u>		
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>London, England.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Hall</u>				14. MOTHER'S MAIDEN NAME <u>Laura M. Powell</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>212-16-0456B</u>		17. INFORMANT <u>Masonic Home, Cockeysville, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Monocytic Leukemia</u> <u>204.2</u> DUE TO <u>3 Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 Chronic Brain Syndrome</u> (c) <u>4 Central arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 15, 1965</u> to <u>8930</u> , 1967 that (I) (we) last saw the deceased alive on <u>8930</u> 1967, and that death occurred at <u>2:00 PM</u> , from causes and on the date stated above.								
22a. SIGNATURE <u>JAMSHID HAMED M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/1/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>JAMSHID HAMED.</u>				22d. ADDRESS <u>MASONIC HOME</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 4, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK Lawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>		
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson,</u>				ADDRESS <u>1050 York Road Towson, Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 5 1967</u>		
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13577

CERTIFICATE OF DEATH

13583

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson			c. LENGTH OF STAY IN 1b 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital				d. STREET ADDRESS 1661 SALEM AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALEXANDER RANDOLPH PERROTT				4. DATE OF DEATH Month 10 Day 28 Year 1967			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-2-06		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Appliance Serviceman		10b. KIND OF BUSINESS OR INDUSTRY Furniture Store		11. BIRTHPLACE (County & State, or foreign country) CHARLTON, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JACOB PERROTT				14. MOTHER'S MAIDEN NAME EFFIE BERTELS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-889		17. INFORMANT Address Records at Mount Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 0021 FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from OCT. 3, 1967 , to OCT. 28, 1967 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 12:50 PM , from causes and on the date stated above.							
22a. SIGNATURE W. Newcomer				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) William Newcomer, M.D.				22d. ADDRESS Mount Wilson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash. Md.	
24. FUNERAL DIRECTOR Ralph W. Martin				ADDRESS 1661 Penna. Ave.		25a. REC'D BY REGISTRAR OCT 31 1967	
				25b. REGISTRAR'S SIGNATURE R. Charles Jones			

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DEPARTMENT OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13584

Item #7 Film #G393 10/19/67 ph

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>521 Sussex Road</u>		d. STREET ADDRESS <u>521 Sussex Road</u>	
3. NAME OF DECEASED (Type or print) <u>Kathryn Charlotte Perry</u>		4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1904</u>
9. AGE (In years lost birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>03</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>03</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Perk typist retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto, County</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George A. Ooden</u>	
14. MOTHER'S MAIDEN NAME <u>Bertha Brant</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>none</u>	
16. SOCIAL SECURITY NO. <u>220-12-7578</u>		17. INFORMANT <u>Family records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissecting Aneurysm</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>of Ascending Aorta</u> DUE TO (c) <u>Hypertensive Cardiac Renal Vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 19, 1966</u> to <u>October 8, 1967</u> , that (I) <u>last</u> saw the deceased alive on <u>Sept 19, 1966</u> and that death occurred at <u>4:04</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Charles F. O'Donnell</u>		22b. DATE SIGNED <u>October 10, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>		22d. ADDRESS <u>M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Woodlawn Md.</u>
24. FUNERAL DIRECTOR <u>John Burns Sons</u>		25a. REC'D BY REGISTRAR <u>Towson, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 16 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1901

STATE OF OHIO

1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13579

13585

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY 			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor Nursing Home				d. STREET ADDRESS Roland Ave. & Rectory Lane			
3. NAME OF DECEASED (Type or print) First Middle Last Marguerite Easter Peterson				4. DATE OF DEATH Month Day Year 10-17-1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-1883	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Easter				14. MOTHER'S MAIDEN NAME Marguerite Miller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-1888		17. INFORMANT Address Owings, Mills Mrs. George P. Ward 2117 Valley Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast - metastasis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus, arteriosclerotic heart disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1955 to Oct 17, 1967 , that (I) lost lost the deceased alive on 16 Oct 1967 , and that death occurred at 2A M, from causes on and on the date stated above.							
22a. SIGNATURE Paul H Royce				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 17 Oct 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Paul Royce				22d. ADDRESS 1403 Foley Lane Pikesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-19-67		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville, Md.	
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co				25a. REC'D BY REGISTRAR DATE OCT 17 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jager	

MEMORANDUM FOR THE DIRECTOR

TO : DIRECTOR, FBI

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

REFERENCE: [Illegible]

ENCLOSURE: [Illegible]

ADMINISTRATIVE: [Illegible]

DISCUSSION: [Illegible]

CONCLUSION: [Illegible]

RECOMMENDATION: [Illegible]

ADMINISTRATIVE: [Illegible]

DISCUSSION: [Illegible]

CONCLUSION: [Illegible]

RECOMMENDATION: [Illegible]

ADMINISTRATIVE: [Illegible]

DISCUSSION: [Illegible]

CONCLUSION: [Illegible]

RECOMMENDATION: [Illegible]

13580

13586

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> 03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>125 FOREST DRIVE</u>		d. STREET ADDRESS <u>125 FOREST DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>CARRIE GREY PHILLIPS</u> First Middle Last		4. DATE OF DEATH <u>OCT 10</u> 19 <u>67</u> Month Day Year	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/24/92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHARM.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RET.</u>	9. AGE (In years last birthday) <u>75</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>GEORGE W. MOSSOP</u>		14. MOTHER'S MAIDEN NAME <u>SADIE BLUMENTHAL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. NELVA C. ACKMAN</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia 3 days</u> <u>1991</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized Adeno-Carcinoma</u> DUE TO (c) <u>General Metastasis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>35</u> , to <u>Oct 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 10</u> , 19 <u>67</u> , and that death occurred at <u>8:05 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Wetherbee Fort</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Wetherbee Fort</u>		22d. ADDRESS <u>6 Dutton Ave. Balto. 21215</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO Md.</u>
24. FUNERAL DIRECTOR <u>E.S. MACNAB</u>		25a. REC'D BY REGISTRAR <u>21228</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>OCT 16 1967</u>	

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

OFFICE OF THE DIRECTOR OF THE BUREAU OF THE ARMY

1000

1000

TO THE DIRECTOR OF THE BUREAU OF THE ARMY
FROM THE DIRECTOR OF THE BUREAU OF THE ARMY
SUBJECT: [Illegible]
[Illegible text follows in several paragraphs, including mentions of 'The Bureau of the Army' and 'The Bureau of the Navy']

Very respectfully,
[Illegible signature]
[Illegible title]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13581											
1. PLACE OF DEATH a. COUNTY Baltimore						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cockeysville,					
c. LENGTH OF STAY IN 1b 1 day						d. STREET ADDRESS Sherwood Road					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM BRAND PINDELL Jr.						4. DATE OF DEATH Month Day Year 10 17 19 67					
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 16, 1910		9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Dairy		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William B. Pindell Sr.						14. MOTHER'S MAIDEN NAME Emily Buck					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 213-12-4821		17. INFORMANT David Lee Pindell				Address Western Run Road Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE 443X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/16 1967, to 10/17 1967, that (I) (we) last saw the deceased alive on 10/17 1967, and that death occurred at 3:07a M, from the causes and on the date stated above.											
22a. SIGNATURE John E. Adams						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/17/67			
22c. PHYSICIAN'S NAME (Type) John E. Adams, M. D.						22d. ADDRESS Greater Baltimore Medical Center					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-19-1967		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery				23d. LOCATION (City, town or county) (State) Pikesville, Maryland			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Road 21204						25a. REC'D BY REGISTRAR DATE OCT 18 1967		25b. REGISTRAR'S SIGNATURE John Charles Judge			

OCT 18 1967

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13582

13588

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson			c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital				d. STREET ADDRESS 27 Rosewood Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD First JAMES Middle POE Last				4. DATE OF DEATH Month 10 Day 29 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1.9. 1900		9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ELI POE				14. MOTHER'S M maiden NAME ANNA AMBROSE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-9081		17. INFORMANT Address Records at Mount Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA & CONGESTION 5021 DUE TO BRONCHITIS, CHRONIC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) POE DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA of HYPOPHARYNX; PULM. EMPHYSEMA							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10.12. 1967 to 10.29. 1967 that (I) (we) last saw the deceased alive on 10.29. 1967 , and that death occurred at 4:15 M, from causes and on the date stated above.							
22a. SIGNATURE William Newcomer				22b. DATE SIGNED 10.29.1967		22c. PHYSICIAN'S NAME (Type) William Newcomer, M.D.	
22d. ADDRESS Mount Wilson, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 2, 1967		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Woodlawn Maryland	
24. FUNERAL DIRECTOR A. J. Schhardt				25a. RECEIVED BY REGISTRAR NOV 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS Owings Mills, Md.				DATE			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13589

13583

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, Towson, Md. 21204						e. STREET ADDRESS 207 Donnybrook Lane, 21204	
3. NAME OF DECEASED (Type or print) William Montgomery POMEROY				4. DATE OF DEATH Month October Day 14 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-19-84		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Yard		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert J. Pomeroy				14. MOTHER'S MAIDEN NAME Louise Beatty			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220 44 6381		17. INFORMANT Address Della Pettie 207 Donnybrook Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Thromboembolism DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9-20 , 19 67 , to 10-14 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-14 19 67 , and that death occurred at 2:20 PM from causes and on the date stated above.							
22a. SIGNATURE 				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-14-67	
22c. PHYSICIAN'S NAME (Type) Dr. Reynaldo Orjuela-Gomez				22d. ADDRESS 7620 York Road, Baltimore, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-17-67		23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK Cem		23d. LOCATION (City or Town) (County) (State) Woodlawn Balto Md	
24. FUNERAL DIRECTOR Burges Funeral Home 3631 Falls Rd Balto				25a. REC'D BY REGISTRAR DATE OCT 17 1967		25b. REGISTRAR'S SIGNATURE 	

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

REPORT OF INVESTIGATION

Subject:

Reference:

On or about [illegible] at [illegible]

by [illegible]

and [illegible]

at [illegible]

by [illegible]

and [illegible]

and [illegible]

and [illegible]

and [illegible]

and [illegible]

and [illegible]

and [illegible]

and [illegible]

and [illegible]

and [illegible]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b <u>03.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>618 S. Marlyn Avenue</u>		d. STREET ADDRESS <u>618 S. Marlyn Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Vera</u> Middle <u>K.</u> Last <u>Price</u>		4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 3, 1903</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry J. Kyle</u>		14. MOTHER'S MAIDEN NAME <u>Sally J. Walker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>233-72-4201</u>	
17. INFORMANT <u>Mr. David J. Price</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> DUE TO (b) <u>Hypertension Cardiovascular</u> DUE TO (c) <u>Ischemic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Ca of uterus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour d.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Theo C. Patterson</u> M.D.		22. DATE SIGNED <u>10/9/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sherwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Salem Virginia.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto, Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 9 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13583

13591

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>523 Allegheny Avenue</u>		d. STREET ADDRESS <u>523 Allegheny Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Boyd</u> Last <u>Raphel</u>		4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>July 26, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (In years last birthday) <u>78</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Taylor Boyd</u>		14. MOTHER'S MAIDEN NAME <u>Olivia Dobbshell Darnell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4500</u> IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/19</u> , 19 <u>62</u> , to <u>10/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/4</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Lawrence C. Post</u>		22b. DATE SIGNED <u>10/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LAWRENCE C Post</u>		22d. ADDRESS <u>6805 York Rd - Balto 2112</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Stephen's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Bradshaw, Maryland</u>
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>Oct 6</u> 19 <u>67</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1941

UNITED STATES

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13586

CERTIFICATE OF DEATH

13592

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 717 S. Glover Street	
3. NAME OF DECEASED (Type or print) John Reich		4. DATE OF DEATH Month 10 Day 28 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-02
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 0 Days 28 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Can	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Reich		14. MOTHER'S MAIDEN NAME Anna Krug	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 212-09-4926	
17. INFORMANT Mrs. Mary E. Reich		Address 717 S. Glover St. Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 21 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-8-1957 , to 10-21-1967 , that (I) (we) last saw the deceased alive on 10-21-1967 , and that death occurred A.M. , from causes and on the date stated above.			
22a. SIGNATURE John J. Gould		22b. DATE SIGNED 10-30-67	
22c. PHYSICIAN'S NAME (Type) John J. Gould		22d. ADDRESS 14th E. AVE. 21224	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/31/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Nicholas T. Matthews		25a. REC'D BY REGISTRAR NOV 1 1967	
ADDRESS 3021 Eastern Ave. Baltimore, Md.		25b. REGISTRAR'S SIGNATURE John J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1997

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13587

CERTIFICATE OF DEATH

13593

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Resident before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u> <u>03-1</u>	
c. LENGTH OF STAY IN TB <u>Life</u>		d. STREET ADDRESS <u>818 Kingston Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>818 Kingston Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALICE</u> First <u>Angela</u> Middle <u>Reilly</u> Last		4. DATE OF DEATH Month <u>Oct</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 5 - 1877</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William P. Reilly</u>		14. MOTHER'S MAIDEN NAME <u>MARY BYRNE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Family Records</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>1530</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>of Lung & Liver</u> DUE TO (c) <u>Carcinoma of Lung & Liver</u> <u>Ascending</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 Month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/6</u> , 19 <u>45</u> , to <u>10/24</u> , 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>10/22</u> 19 <u>67</u> , and that death occurred at <u>9:14</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Charles F O'Donnell</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10-24-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Charles F O'Donnell</u>		22d. ADDRESS <u>2501 York Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-26-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO MD</u>
24. FUNERAL DIRECTOR <u>CHAR. T. EVANS & Son</u> ADDRESS <u>8802 Hartford Rd</u>		25a. RECD BY REGISTRAR DATE <u>OCT 26 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13588

13584

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Marriottsville</u>		c. LENGTH OF STAY IN It <u>Life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Marriottsville</u>		d. STREET ADDRESS <u>WARDS Chapel Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WARDS Chapel Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry Reisberg</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-6-1892</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anton Reisberg</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Stockdale</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-14-7598</u>	
17. INFORMANT <u>Mrs. Edna Reisberg - Marriottsville</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AS C.V.D.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , to <u>10/13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/12</u> , 19 <u>67</u> , and that death occurred at <u>2 P.M.</u> from causes on the date stated above.			
22a. SIGNATURE <u>W. J. Ellis</u>		22b. DATE SIGNED <u>10/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Mr. J. Ellis, M.D.</u>		22d. ADDRESS <u>Randallstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-16-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WARDS Chapel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. Co. Md.</u>
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>		25a. REC'D BY REGISTRAR <u>Oct 17 1967</u>	
ADDRESS <u>Lykesville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1338

STATE OF TEXAS

1338

County of ... State of Texas
I, the undersigned, Clerk of the County of ... State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of ... State of Texas.
Witness my hand and the seal of said County at the City of ... State of Texas, this ... day of ... 19...
Clerk of the County of ... State of Texas

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

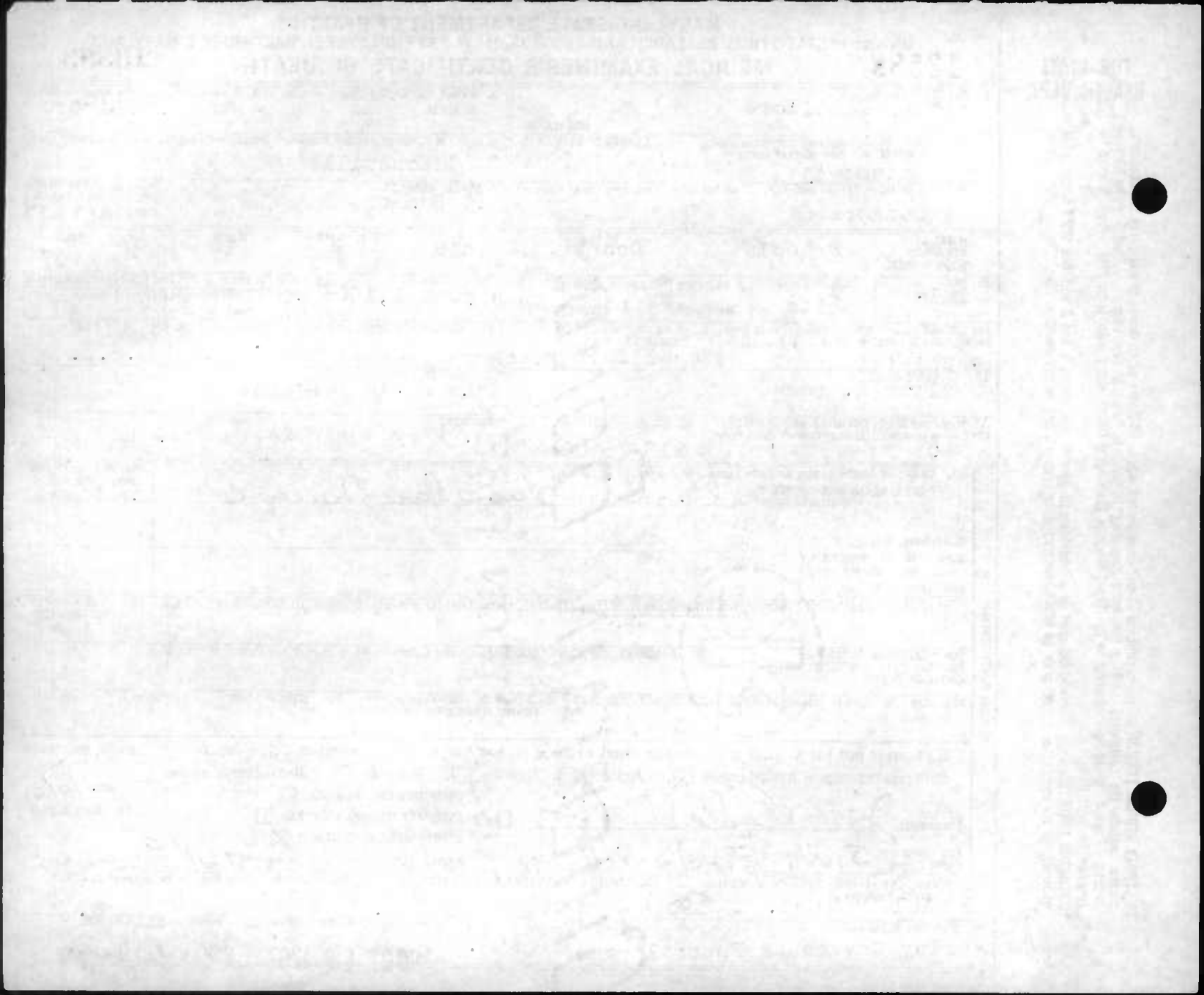
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13589

13595

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 24 Dunmore Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Francis Doory Resau		4. DATE OF DEATH Month 10 Day 9 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 1, 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10b. KIND OF BUSINESS OR INDUSTRY Naval Ship research Center	11. BIRTHPLACE (State or foreign country) MD.
13. FATHER'S NAME Walter A. resau		14. MOTHER'S MAIDEN NAME Anna Marie DeMinnis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218 76 0094	
17. INFORMANT Mrs. Mary Resau		Address 24 Dunmore Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE J. N. Frederick		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) J. N. Frederick MD		Address (Street, city, town, or county) 1311 Francis Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 13 1967	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	23d. LOCATION (City, town or county) (State) Baltimore MD
24. FUNERAL DIRECTOR Farley Cavanaugh Funeral Home		25a. REC'D BY REGISTRAR OCT 13 1967	
ADDRESS 6001 Frederick Ave.		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13596

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore County General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 8407 Liberty Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James V. Reynolds		4. DATE OF DEATH Month 10 Day 30 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-98
9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY Woodruff Rubber Co.	
11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mark E. Reynolds		14. MOTHER'S MAIDEN NAME Maude Greaver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-03-3773	
17. INFORMANT Mrs. E. Ruth Reynolds		Address 8407 Liberty Rd Baltimore 7 Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) CORONARY - Myocardial insufficiency		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Diffuse pulmonary edema & chronic passive congestion		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-28 , 19 67 , to 10-30 , 19 67 That (I) (we) last saw the deceased alive on 10-30 19 67 , and that death occurred at 9:30 M, from causes and on the date stated above.			
22a. SIGNATURE ANGELITA DPAW		22b. DATE SIGNED 10-30-67	
22c. PHYSICIAN'S NAME (Type) ANGELITA DPAW		22d. ADDRESS BCSA	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE/THEREOF 11/2/67	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) (State) Woodlawn Balto Md	
24. FUNERAL DIRECTOR Foring Myers		25a. REC'D BY REGISTRAR NOV 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1941

DEPARTMENT OF HEALTH

1941

Case 4, four primary culture & clinical examination
Coronary - the central vasculature

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13591

13597

1. PLACE OF DEATH e. COUNTY <u>Baltimore County</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Overlea</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7214 Linden Ave</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Overlea</u> d. STREET ADDRESS <u>7214 Linden Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Mariah</u> Last <u>Rhodes</u>				4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 18, 1891</u>		9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Rev. William Morman</u>				14. MOTHER'S MAIDEN NAME <u>Millie ?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mr. Luther E. Rhodes 7214 Linden Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular stroke accident</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u>Arteriosclerotic vascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>several</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>Baltimore</u> <u>Maryland</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>8 31</u> to <u>6 4 10-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-2</u> , 19 <u>67</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Richard R. Rigler</u>				22b. DATE SIGNED <u>10-19-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Richard R. Rigler, M.D.</u>		22d. ADDRESS <u>1 W. Overlea Ave. Balto., Md. 2120</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Auburn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Nutter</u>				24b. ADDRESS <u>3035 W. North Ave</u>		25a. REC'D BY REGISTRAR <u>OCT 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1961

CERTIFICATE OF DEATH

1961

10

OCT 10 1961

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13592

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13598

1. PLACE OF DEATH a. COUNTY Baltimore 21204 MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 30-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			d. STREET ADDRESS 504 Castle Drive		
3. NAME OF DECEASED (Type or print) First Ethel Middle Isabelle Last Ricker			4. DATE OF DEATH October 7 1967 Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1887		9. AGE (In years last birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Drug Dept.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S. A.
13. FATHER'S NAME Chas. Ricker			14. MOTHER'S MAIDEN NAME Agnes Galloaway		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-28-9748A		17. INFORMANT Address Mr. Geo. Cristie-504 Castle Dr. 21212	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Systemic (b) Internal Hemorrhage & Fracture 7 Days DUE TO of belt & pipe (c) Internal Hemorrhage PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Struck by Automobile					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by Automobile			
20c. TIME OF INJURY Month, Day, Year 12+ p.m. 9/30 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) Baltimore City Md.		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 1077/67			
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		22. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/10/67		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.	
23d. LOCATION (City or Town) Towson, Md.		23e. (County) (State)			
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd-21212		25a. REC'D BY REGISTRAR OCT 11 1967			
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon properly. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13593

13599

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. LENGTH OF STAY IN 1b 48 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ralph Middle Robinson Last Robinson		4. DATE OF DEATH Month 10 Day 12 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2.28.1892
9. AGE (In years lost birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rivet Clerk Racetrack		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin Robinson		14. MOTHER'S MAIDEN NAME Emma Funk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 265-01-9538	
17. INFORMANT Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary 0021 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) tuberculosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8.25 , 19 67 , to 10.12 , 19 67 , that (I) (we) last saw the deceased alive on 10.12 , 19 67 , and that death occurred at 2:40 AM, from causes on and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 10.12.1967	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Supt.		22d. ADDRESS Mt. Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY St. Anthony's		23d. LOCATION (City or town) (County) (State) BALTIMORE Md.	
24. FUNERAL DIRECTOR Frank H. Newell		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 13 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13594

13600

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 230 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 312 ALBEMARLE STREET	
3. NAME OF DECEASED (Type or print) First ROBERT Middle JEROME Last ROCHFORD, JR.		4. DATE OF DEATH Month OCTOBER Day 18 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 26, 1917
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIP FITTER		10b. KIND OF BUSINESS OR INDUSTRY SHIPYARD	9. AGE (In years lost birthday) yrs. 50
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT J. ROCHFORD, SR.		14. MOTHER'S MAIDEN NAME ADELAIDE SELLA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW II		16. SOCIAL SECURITY NO. 215 05 18 17	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA WITH PULMONARY ABSCESSSES 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOGENIC CARCINOMA, RIGHT LUNG DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE. ARTERIOSCLEROSIS, MARKED, GEN.		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 3/2/67 , 19__ to 10/18/67 , 19__, that (X) (we) lost saw the deceased alive on 10/18/67 , 19__, and that death occurred on 10:55 PM from causes and on the date stated above.			
22a. SIGNATURE <i>Peter V. Juvan</i>		22b. DATE SIGNED 10/20/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/23/67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>Joseph N. Zannino</i>		25a. REC'D BY REGISTRAR ZANNINO FUNERAL HOME 257 S. CONKLING ST. BALTIMORE, MD.	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE OCT 24 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTO. Co. MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FULLERTON c. LENGTH OF STAY IN 1b 10 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4203 RAAB AVE. BALTO. 21236				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MD. f. COUNTY BALTO. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FULLERTON d. STREET ADDRESS 4203 RAAB AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WACLAW J. ROGUSKI		4. DATE OF DEATH Month Day Year OCT. 25 19 67		5. SEX MALE			
6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 5, 1889			
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FURNACE HELPER		10b. KIND OF BUSINESS OR INDUSTRY COPPER WORKS		11. BIRTHPLACE (County & State, or foreign country) POLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN ROGUSKI					
14. MOTHER'S MAIDEN NAME BERTHA GIZENSKA				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 312-10-1016				17. INFORMANT JOSEPHINE ROGUSKI			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral ischemia, severe DUE TO (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Terminal pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH 3 years 10 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 				20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 			
21. I certify that (I) (this hospital) attended the deceased from 4-27-64 19 to 10-25-67 19 that (I) (we) last saw the deceased alive on 10-23-67 19 and that death occurred 5:15 p.m. the causes and on the date stated above.							
22a. SIGNATURE <i>Theodore E. Evans</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 10-25-67			
22c. PHYSICIAN'S NAME (Type) Theodore E. Evans, M.D.				22d. ADDRESS 9660 Belair Road 21236			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 28, 1967		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM.			
23d. LOCATION (City, town or county) BALTO.		(State) MD.					
24. FUNERAL DIRECTOR'S SIGNATURE WM. FIALKOWSKI		ADDRESS 2007 EASTERN AVE		25a. REC'D BY REGISTRAR OCT 27 1967			
WM. Fialkowski		BALTO. MD. 21231					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY		BALTIMORE		a. STATE		MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		FORT HOWARD		c. LENGTH OF STAY IN 1b		16 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS		1615 PARK AVENUE			
e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			
GEORGE E. ROSENBRICK						Month Day Year			
						OCTOBER 15 1967			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7/1/90		77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
PARKING LOT ATTENDANT				BALTIMORE, MARYLAND		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
CHRISTIAN ROSENBRICK				MARGARET MILLER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT					
YES WWI		219 28 25 87		CLINICAL RECORDS, VAH, FT. HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN DEATH	
PART I. DEATH WAS CAUSED BY: <td colspan="2">RECENT</td>								RECENT	
IMMEDIATE CAUSE (a) PULMONARY EDEMA AND CONGESTION									
DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								(b) CORONARY ARTERY THROMBOSIS	
DUE TO								RECENT	
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED?	
PULMONARY HEART DISEASE, OLD. PULMONARY EMPHYSEMA, OLD. ARTERIOSCLEROSIS MARKED, GENERALIZED, OLD. BENIGN PROSTATIC HYPERTROPHY, OLD								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year	
								Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 9/29/67, 19 to 10/15/67, 19, that (we) last saw the deceased alive on 10/15/67, 19, and that death occurred at 8:45AM from causes and on the date stated above.								22b. DATE SIGNED	
22a. SIGNATURE				PETER V. JUVAN, M.D.				10/16/67	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS				22e. REC'D BY REGISTRAR	
				VAH FORT HOWARD, MARYLAND				22f. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		10/18/67		BALTIMORE NATIONAL		BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				WITZKE FUNERAL HOME		DCT 17 1967		Charles Judge	
				EDMONDSON AVE. BALTIMORE, MD.					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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13597

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>309 Church Lane</u>		d. STREET ADDRESS <u>309 Church Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Reginald</u> First Middle Last		4. DATE OF DEATH <u>Rosevear Jr.</u> Month Day Year <u>October 4, 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1904</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman for Westinghouse Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicago Ill.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Reginald Rosevear Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Jane E. Ireland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>160-03-5195</u>	
17. INFORMANT <u>Mrs. Anne M. Rosevear</u>		Address <u>Pikesville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerosis Cardiovascular Disease</u> DUE TO (c) <u>5 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>October 1, 1967</u> to <u>October 4, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 28, 1967</u> , and that death occurred at <u>7:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Benjamin Berdann</u>		22b. DATE SIGNED <u>10-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Benjamin Berdann, M.D.</u>		22d. ADDRESS <u>615 Hammonds Lane, Baltimore, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 7, 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Philadelphia, Penna.</u>
24. FUNERAL DIRECTOR <u>Tipton-Eline Funeral Home</u>		25a. RECEIVED BY REGISTRAR <u>Oct 6 1967</u>	
ADDRESS <u>Hampstead, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13598

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13604

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto - Rural	
c. LENGTH OF STAY IN 1b unk		d. STREET ADDRESS 8687 Oak Rd 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8687 Oak Rd 21234		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First A.ester Middle Rosier Last		4. DATE OF DEATH Month 10-6 Day 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 28 Nov 23
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Bolt Mgrs.	
11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Rosier		14. MOTHER'S MAIDEN NAME Ida Myers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 234 30 1341	
17. INFORMANT Harry Rosier		Address Elkins, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (Probable final mechanism: Coronary Occlusion) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John C. Hyle		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN C. Hyle		M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED 10-6-67		Address (Street, city, town, or county) 2577 Belair Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-9-67	23c. NAME OF CEMETERY OR CREMATORY Mouse Cemetery, Elkins,	23d. LOCATION (City or Town) (County) (State) W. Virginia.
24. FUNERAL DIRECTOR Wm.E. Johnson, 8521 Loch Raven Blvd. 21204		25a. REC'D BY REGISTRAR OCT 9 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G394 10/30/67 pm
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13599

13605

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE		c. LENGTH OF STAY IN 1b 4 1/2 yr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore County			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8729 Satyr Hill Road				d. STREET ADDRESS 8729 Satyr Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle JAMES Last ROZNOWSKI				4. DATE OF DEATH Month October Day 23 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 7 - 1936	9. AGE (In years last birthday) 31 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John Roznowski				14. MOTHER'S MAIDEN NAME Olga Nightingale			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 211-28-5331		17. INFORMANT Sadie Roznowski		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning 9731 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Motor running in closed car					
20c. TIME OF INJURY Month, Day, Year Hour a.m. UNK p.m. 10/23 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Garage		20f. (City or town) (County) (State) Baltimore, MD.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D.		Address (Street, city, town, or county)		22. DATE SIGNED 10/24/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-26-67		23c. NAME OF CEMETERY OR CREMATORY Parkmoor		23d. LOCATION (City or town) (County) (State) BALTO MD	
24. FUNERAL DIRECTOR CHAR F EVANS & SON				25a. REC'D BY REGISTRAR OCT 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13606

13600

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN 1b 29½ yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital				d. STREET ADDRESS 919 Homestead Street			
3. NAME OF DECEASED (Type or print) First Eugene Middle Francis Last RUETER				4. DATE OF DEATH Month 10 Day 10 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-12-29	9. AGE (In years lost birthday) 38 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 YEAR Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Baltimore City, Md.9	
13. FATHER'S NAME Bernard Rueter				14. MOTHER'S MAIDEN NAME Marie Anthony			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Rosewood Records, Owings Mills, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Glomerular Nephritis 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) Congestive Heart Failure						INTERVAL BETWEEN ONSET AND DEATH 10 yrs 6 yrs terminal	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from 12/29 , 19 37 , to 10/10 , 1967, that (if we) last saw the deceased alive on 10/10 , 19 67 , and that death occurred at 5:50p , from causes and on the date stated above.							
22a. SIGNATURE Richard A. Jones		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11 Oct 67			
22c. PHYSICIAN'S NAME (Type) Richard A. Jones		22d. ADDRESS Rosewood State Hosp,					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/13/1967		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR Eugenia K. Seitz Seitz Funeral Home				ADDRESS 5209 York Road Balto. Md. 21212		25a. REGISTRATION DATE OCT 13 1967	
				25b. REGISTRAR'S SIGNATURE Judge			

13500

CERTIFICATE OF MARRIAGE

State of Illinois
County of Cook

Spouse of State Hospital

Male
Age
Born
Residence
Occupation

Spouse of Spouse, George W. H. H. H. H.

Chronic Alcohol - Habitual
Hypertension Card. (Hypertension)
Congestive Heart Failure

10 yrs
2 yrs
to marry

Richard A. Jones
Richard A. Jones

11 Oct 67
Cook County State Hosp.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13601

CERTIFICATE OF DEATH

13607

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 341 S. Drew St. #21224 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry J. SCANDORA		4. DATE OF DEATH Month October Day 3 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 27, 1918
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Galvanizer		10b. KIND OF BUSINESS OR INDUSTRY Gen. Elec. Insulat.	
11. BIRTHPLACE (County & State, or foreign country) New York City, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Santo Vasta		14. MOTHER'S MAIDEN NAME Angelina Scandora	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W W 2		16. SOCIAL SECURITY NO. 218-03-9687	
17. INFORMANT Mrs. Antoinette R. Scandora		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY COLLAPSE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METABOLIC DISTURBANCE DUE TO (c) CARCINOMA OF THE LUNG AND LIVER		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 12, 1967 , to October 3, 1967 , that (I) (we) last saw the deceased alive on October 3, 1967 , and that death occurred at 3:00AM from causes and on the date stated above.			
22a. SIGNATURE B. Olives		22b. DATE SIGNED October 3, 1967	
22c. PHYSICIAN'S NAME (Type) B. Olives, M.D.		22d. ADDRESS 7620 York Road Towson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/6/67.	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE OCT 3 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13603 Items #2c & d Film 10/20/67 ph											
13609											
1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Armacost Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 21205 d. STREET ADDRESS 1157 Fraley Way 812 Regester Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Lydia			First Schmidt		Middle Schmidt		Last Schmidt		4. DATE OF DEATH Month 10/17 Day 19 Year 67		
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/5/98		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 30.4 Days 4 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Nurse				10b. KIND OF BUSINESS OR INDUSTRY New Kensington, Pa.		11. BIRTHPLACE (County & State, or foreign country) U.S.A.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME August Bartsch					14. MOTHER'S MAIDEN NAME Elizabeth Holwartz						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 219-30-7417		17. INFORMANT Simon Schonfield Address 1101 Tower building						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, metastatic 172x DUE TO advanced, origin unknown endometrium Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardio Vascular Disease										INTERVAL BETWEEN ONSET AND DEATH 8 yrs	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 3-21- , 19 62 , to 10-17- , 19 67 , that (I) (we) last saw the deceased alive on 10-17- , 19 67 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Mari Hinnno				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 10-18-67			
22c. PHYSICIAN'S NAME (Type) JURI HINNO				22d. ADDRESS 5002 Frankford Rd Baltimore, Md 21206							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/20/67		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery			23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. ADDRESS Baltimore, Md. 21202						25a. REC'D BY REGISTRAR OCT 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13604

13610

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b <div style="text-align: center; width: 100px;">9 years</div> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1001 West Joppa Road, Towson, Md.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY BALTO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 1001 West Joppa Road											
3. NAME OF DECEASED (Type or print) Sister Mary Augustine Schneider				4. DATE OF DEATH Month OCT. Day 9 Year 1967											
5. SEX Female		6. COLOR OR RACE Cau.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1879		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 03 Days 1		IF UNDER 24 HRS. Hours 00 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun				10b. KIND OF BUSINESS OR INDUSTRY Convent				11. BIRTHPLACE (County & State, or foreign country) Heuchelheim, Germany				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Schneider						14. MOTHER'S MAIDEN NAME Catherine Kroeck									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Convent Records, 1001 W. Joppa Road.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Arteriosclerosis Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH Sudden 10 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour 19 e.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 11/17 1959 to 10/9 1967 , that (I) (we) last saw the deceased alive on 10/9 1967 , and that death occurred at _____ M. from the causes and on the date stated above.															
22a. SIGNATURE Charles F. O'Donnell, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 10/11/67					
22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell, M.D.						22d. ADDRESS 7501 York Road									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/12/1967		23c. NAME OF CEMETERY OR CREMATORY Convent Cemetery				23d. LOCATION (City, town or county) (State) 1001 W. Joppa Rd. Towson, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Vernon Lemmon						ADDRESS 4611 Park Heights Av. Balto. Md.				25a. REC'D BY REGISTRAR OCT 13 1967				25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13605

13611

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b Ellicott City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SHADY NOOK NURSING HOME, ROLLING RD.				d. STREET ADDRESS 24 Tyler Drive			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MARY E. SCHNEIDER				4. DATE OF DEATH Month Day Year OCT. 13, 19 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/92		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fuller R. Wright				14. MOTHER'S MAIDEN NAME Mary Warfield			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Lillian Leidner, 24 Tyler Drive 21043			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial failure - 48 hrs. 158X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized pituitary metastatic Carcinoma DUE TO (c) Cause undetermined.							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic C.V. disease.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 19 67 , to Oct. 13 , 19 67 , that (I) (we) last saw the deceased alive on Oct. 12 , 19 67 , and that death occurred at 7:30 A.M. from causes and on the date stated above.							
22a. SIGNATURE D.C. MacLaughlin				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/13/67	
22c. PHYSICIAN'S NAME (Type) D. C. MacLaughlin				22d. ADDRESS Shady Nook Nursing Home, Catons. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/16/67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229				25a. REC'D BY REGISTRAR DATE OCT 16 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13606

CERTIFICATE OF DEATH

13612

1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>307 E. Pennsylvania Ave</u>		d. STREET ADDRESS <u>307 E. Pennsylvania Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>G.</u> Last <u>Schorr Sr.</u>		4. DATE OF DEATH Month <u>October</u> Day <u>13</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 13, 85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>grounds keeper retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	9. AGE (In years last birthday) <u>82</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown dead</u>		14. MOTHER'S MAIDEN NAME <u>unknown dec'd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no none</u>		16. SOCIAL SECURITY NO. <u>212-32-2876</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>10 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> , 19 <u>56</u> , to <u>10/13</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>10/12</u> , 19 <u>67</u> and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>Charles F. O'Donnell</u>		22b. DATE SIGNED <u>10/16/67</u>	22c. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>
22d. ADDRESS <u>7501 York Rd.</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-17-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Morland Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Parkville Md.</u>
24. FUNERAL DIRECTOR <u>John Burns Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 19 1967</u>	

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CERTIFICATE OF DEATH

13613

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY 304			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 21214	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital				d. STREET ADDRESS 2720 Northern Pkwy.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John William Schurman				4. DATE OF DEATH Month Day Year October 12 1967			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 24, 1887	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Tool & Die Maker		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Adolph Schurman			
14. MOTHER'S MAIDEN NAME Marie Momberger				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 216-10-0229				17. INFORMANT Address Mr. Harold Schurman, 6149 Chinquapin Pkwy.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary embolisms 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive heart failure DUE TO (c) Arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from <u>Sept. 3rd, 1967</u> to <u>Oct. 12th 1967</u> , that the (we) last saw the deceased alive on <u>October 12 1967</u> , and that death occurred at <u>3:25AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <i>Lawrence F. Misanik</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-12-67	
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.				22d. ADDRESS 7620 York Rd. Towson, Md. 21204			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/14/67.		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR Oct 13 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13614

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN It d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2902 Dunleer Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 2902 Dunleer Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SARAH SHEPHERD SCHWING First Middle Last 4. DATE OF DEATH October 2, 1967 Month Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH April 25, 1916 9. AGE (In years last birthday) 51 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) West Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jacob E. Shepherd 14. MOTHER'S MAIDEN NAME Sallie Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Dr. Harold E. Schwing Address 2902 Dunleer Road		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Oct 2, 1967 to Oct 2, 1967 that (I) (we) last saw the deceased alive on Oct 2, 1967 and that death occurred at 6:59 A.M. from causes and on the date stated above.		22a. SIGNATURE M.B. Davis M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) M.B. Davis, M.D. 22b. DATE SIGNED 22d. ADDRESS 6800 Mornington Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10/4/67 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery 23d. LOCATION (City or Town) (County) (State) Colgate, Md.		24. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home Dundalk, Md. 25a. REC'D BY REGISTRAR OCT 5 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

2032

STATEMENT OF DEATH

13614

DECLARATION OF DEATH

STATE OF TEXAS

COUNTY OF DALLAS

BEFORE ME, the undersigned authority, on this _____ day of _____, 19____, personally appeared _____, known to me to be the person whose name is subscribed to the foregoing declaration of death, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 19____.

Notary Public in and for the State of Texas

My commission expires this _____ day of _____, 19____.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13608

CERTIFICATE OF DEATH

13615

1. PLACE OF DEATH a. COUNTY <u>Ba/to.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Ba/to AA</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ba/to.</u>			c. LENGTH OF STAY IN 1b <u>2 wks</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ba/to.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shangri-La Nursing Home</u>						d. STREET ADDRESS <u>510 W. Shipley Rd, Luthrum</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Eldridge E Sears</u>				4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1967</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>7/24/85</u>		9. AGE (In years lost birthday) <u>82</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Richard</u>				14. MOTHER'S MAIDEN NAME <u>Mary</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unk</u>			16. SOCIAL SECURITY NO. <u>705-08-1096</u>		17. INFORMANT <u>Hosp Chart</u>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>5271</u> IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Pulmonary Embolism</u> stating the underlying cause lost. (c) <u></u>									INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>30 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10/2</u> , 1967, to <u>10/15</u> , 1967, that (I) (we) last saw the deceased alive on <u>10/15</u> , 1967, and that death occurred at <u>M</u> , from causes and on the date stated above.										
22a. SIGNATURE <u>[Signature]</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/16/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>W F W Lane, Ellicott City Md.</u>					22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>18 Oct. 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Galesville, AA Co., Md.</u>		
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>OCT 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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529-81-739

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13610

CERTIFICATE OF DEATH

13616

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
a. COUNTY <u>BALTIMORE</u> County MARYLAND				a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>201 Goodwood Road</u>			
c. LENGTH OF STAY in 1b <u>3 hrs 25 min</u>				d. STREET ADDRESS <u>201 Goodwood Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>San Clark Sener</u>				4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/8/1924</u>	
9. AGE (In years lost birthday) <u>43</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Stamford Conn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John A. Ten Eyke</u>				14. MOTHER'S MAIDEN NAME <u>Partridge, Florence</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>049-165317</u>		17. INFORMANT <u>Patients Chart</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Symphangitic Carcinomatosis in both lungs</u> DUE TO (c) <u>Secondary To Rt. breast C.A.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6 P.M. 10-2</u> , 19 <u>67</u> , to <u>9:25 10-2-1967</u> , that (I) (we) last saw the deceased alive on <u>9-24 10-2</u> , 19 <u>67</u> , and that death occurred at <u>9:25 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Rahim Bassir</u>				22b. DATE SIGNED <u>10-2-67 9:30</u>		22c. PHYSICIAN'S NAME (Type) <u>Rahim Bassir</u>	
22d. ADDRESS <u>GBMC, Towson, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>10-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>				25a. REC'D BY REGISTRAR <u>to DATE OCT 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1881

CERTIFICATE OF DEATH

1881



[Faint, mostly illegible text, likely a death certificate or official record. The text is mirrored across the page, suggesting bleed-through from the reverse side.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13617

13611

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 13 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lothian		d. STREET ADDRESS 29 Patuxent Mobile Estates	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sandra Middle Jean Last SHAW		4. DATE OF DEATH Month 10 Day 16 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-5-66
9. AGE (In years lost birthday) 1 yrs.		IF UNDER 1 YEAR Months 5 Days	IF UNDER 24 HRS Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (County & State, or foreign country) Ann Arbor, Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Harold Shaw	
14. MOTHER'S MAIDEN NAME Carol Jean Reynolds		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Rosewood Records, Owings Mills, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute passive Congestive Pulmonary 752X DUE TO Cerebral insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Noncommunicating Hydrocephalus (c) terminal 17 months		INTERVAL BETWEEN ONSET AND DEATH 1 year 17 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from 10/3 , 19 67 , to 10/16 , 19 67 that (b) (we) last saw the deceased alive on 10/16 , 19 67 , and that death occurred at 7:45am , from causes and on the date stated above.			
22a. SIGNATURE Richard A. Jones		22b. DATE SIGNED 10-16-67	
22c. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.		22d. ADDRESS Rosewood State Hosp., Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/19/67	23c. NAME OF CEMETERY OR CREMATORY Glen Eden Lutheran	23d. LOCATION (City or town) (County) (State) Wayne Co. Michigan
24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.		25a. REC'D BY REGISTRAR DATE OCT 18 1967	
25b. REGISTRAR'S SIGNATURE William S. Judge			

1961

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BOARD OF

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13612

CERTIFICATE OF DEATH

13618

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson			c. LENGTH OF STAY IN 1b 31 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 21222 03-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital				d. STREET ADDRESS 222 S. Woodwell Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle Brooks Last SHAW, Sr				4. DATE OF DEATH Month October Day 19 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4-25-94		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAR INSPECTOR RAIL ROAD			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 70510-6496		17. INFORMANT Records, Mt. Wilson State Hospital		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Pulmonary Emphysema DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH one month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-18 , 19 67 , to 10-19 , 19 67 , that (I) (we) last saw the deceased alive on 10-19 19 67 , and that death occurred at 11 P -M, from causes and on the date stated above.							
22a. SIGNATURE W Newcomer				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-19-67	
22c. PHYSICIAN'S NAME (Type) William Newcomer, M.D. Supt.				22d. ADDRESS Mt. Wilson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/23/67		23c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE		23d. LOCATION (City or Town) (County) (State) DORSEY, MD.	
24. FUNERAL DIRECTOR W. Brooks Buckley, Dundalk, Md.				25a. REC'D BY REGISTRAR DATE OCT 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1901

OFFICE OF THE
DIRECTOR

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13619

CERTIFICATE OF DEATH

13613

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. LENGTH OF STAY IN 1b <u>8 yrs</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				d. STREET ADDRESS <u>1300 Poplar Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1300 Poplar Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary M. Shek</u>				4. DATE OF DEATH <u>October 16</u> 19 <u>67</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/10/81</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Adam Kreiner</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-48-4955</u>			
17. INFORMANT <u>Dolores Shek</u>				Address <u>1300 Poplar Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Hypertensive Cardio Vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) <u>Diabetes mellitus</u> lost. (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 9</u> , 19 <u>67</u> , to <u>Oct 16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 9</u> , 19 <u>67</u> , and that death occurred at <u>10</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Edgar Williamson</u>				22b. DATE SIGNED <u>10/16/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edgar Williamson</u>				22d. ADDRESS <u>5550 Balto. National Pkce</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR <u>Ambrose Inc</u>				25a. REC'D BY REGISTRAR <u>OCT 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodstock, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto. County General Hospital</u>		d. STREET ADDRESS <u>Wrights Mill Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Gilbert K. Shifflett</u>		4. DATE OF DEATH <u>10/14</u> 19 <u>67</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/30/02</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Silas William Shifflett</u>		14. MOTHER'S MAIDEN NAME <u>Susanna Mobrey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-4015</u>	
17. INFORMANT <u>FANNIE SHIFFLETT</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - Vascular Disease</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>problem</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>J. N. Frederick MD</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>J. N. Frederick MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-18-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LAKE VIEW</u>		23d. LOCATION (City or Town) (County) (State) <u>54 KESVILLE CARROLL and</u>	
24. FUNERAL DIRECTOR <u>Regulation - Stark Elmer City</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <u>OCT 18 1967</u>	

10/14/67

22. DATE SIGNED

1311 Francis Ave
Baltimore, Md. 21227

12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 4 should be retained by the hospital or attending physician. Page 2 of 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
13615 CERTIFICATE OF DEATH 13621														
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN c. LENGTH OF STAY IN b. 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Baltimore Co. General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1902 Dunhill Village Circle Apt. 104 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Abraham First Middle Last 4. DATE OF DEATH 5 10 6 1967 Month Day Year					5. SEX MALE 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 4-25-96 9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCER 10b. KIND OF BUSINESS OR INDUSTRY RETAIL 11. BIRTHPLACE (County & State, or foreign country) Poland. 12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Sidney Shuster 14. MOTHER'S MAIDEN NAME ETHEL I. MRS. MARY SHUSTER									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes W.W.I. 16. SOCIAL SECURITY NO. 088-16-4219 17. INFORMANT XXXXXXXXXX Address 7902 DUNHILL VILLAGE CIRCLE, APT. 104					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bilateral 4221 DUE TO (b) Pulmonary Infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Acute Pulmonary Edema 2° AS COP.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from 10-2 1967 to 10-6 1967 , that (I) (we) last saw the deceased alive on 10-6 1967 , and that death occurred at 5:45 pm from the causes and on the date stated above.														
22a. SIGNATURE Diadema Simon, M.D. 22c. PHYSICIAN'S NAME (Type) Diadema Simon, M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF 10-8-67					23c. NAME OF CEMETERY OR CREMATORY SWINICHER WOLINER				
24 FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD					ADDRESS BALTIMORE, MARYLAND					25a. REC'D BY REGISTRAR OCT 11 1967 25b. REGISTRAR'S SIGNATURE Charles Judge				

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101 LEVINSKY & SONS, INC., 4015 REGISTERED ROAD, BALTIMORE, MARYLAND

101 LEVINSKY & SONS, INC.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
BALTIMORE		BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6009 UPDALE COURT		d. STREET ADDRESS 6009 UPDALE COURT #21207	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BESSIE Middle SIEGEL Last SIEGEL		4. DATE OF DEATH Month OCTOBER Day 9 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 13, 1886
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (County & State, or foreign country) LATVIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB FRANK		14. MOTHER'S MAIDEN NAME MARGOLA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MISS ESTHER FRANK SIEGEL, #XXX#6009 UPDALE CT.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) 10+ years		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HCVD		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May , 19 60 , to 9 Oct , 19 67 that (I) (we) last saw the deceased alive on 9 Oct , 19 67 , and that death occurred at 11A M, from causes and on the date stated above.			
22a. SIGNATURE DR. MARVIN H. DAVIS		22b. DATE SIGNED 10 Oct 1967	
22c. PHYSICIAN'S NAME (Type) DR. MARVIN H. DAVIS		22d. ADDRESS 6512 LIBERTY ROAD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-12-67	
23c. NAME OF CEMETERY OR CREMATORY BETH ISRAEL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD.		25a. REC'D BY REGISTRAR OCT 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

3313

STATE OF TEXAS

COUNTY OF DALLAS

OFFICE OF THE

CLERK OF THE DISTRICT COURT

IN RE: JAMES EARL RAY

VS. THE STATE OF TEXAS

DEFENDANT

PROSECUTOR

THE STATE OF TEXAS

VS. JAMES EARL RAY

IN RE: JAMES EARL RAY

VS. THE STATE OF TEXAS

JAMES EARL RAY

VS. THE STATE OF TEXAS

IN RE: JAMES EARL RAY

VS. THE STATE OF TEXAS

IN RE: JAMES EARL RAY

VS. THE STATE OF TEXAS

VS. JAMES EARL RAY

VS. THE STATE OF TEXAS

VS. JAMES EARL RAY

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13617

CERTIFICATE OF DEATH

13623

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Va.</u> b. COUNTY <u>Lancaster</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pilmerock</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4412 Ridge Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SUSIE T. SIMMONS</u> First Middle Last		4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1896</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Whitestone, Va.</u>	
13. FATHER'S NAME <u>Henry Temple Towles</u>		14. MOTHER'S MAIDEN NAME <u>Sidney Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>224-42-1952B</u>	
17. INFORMANT <u>George R. Simmons</u>		Address <u>4412 Ridge Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the breast</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Generalized Metastases sec to a</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-30</u> , 19 <u>67</u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>3 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Manuel J. Rodriguez</u> M.D.		22b. DATE SIGNED <u>10-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MANUEL J. RODRIGUEZ</u>		22d. ADDRESS <u>1424 Old Sulphur Spring Rd. Baltz</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Whitestone Me. Ch. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Whitestone Va.</u>
24. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home</u> <u>Balto., Md. 21212</u>		25. REC'D BY REGISTRAR DATE <u>NOV 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

<div>13618</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>13624</div>									
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY _____				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 20 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE # 21224 , 30-4				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL					d. STREET ADDRESS 417 SOUTH DREW STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last SLITZER					4. DATE OF DEATH Month OCTOBER Day 8, Year 1967				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/3/94		9. AGE (In years last birthday) yrs. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN, BALTO. CITY		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM SLITZER					14. MOTHER'S MAIDEN NAME MARY VAN HEEN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WWI 217 38 57 65		17. INFORMANT Address CLINICAL RECORDS, VAH, FT. HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA 1979 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RHABDOMYOSARCOMA DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EDEMA								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that the (this hospital) attended the deceased from SEPT 18, 1967 to OCT 8, 1967 , that he (we) last saw the deceased alive on OCT 8, 1967 , and that death occurred at 11:45 PM , from causes and on the date stated above.									
22a. SIGNATURE <i>John D. Talbert</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/10/67		
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.					22d. ADDRESS VAH FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-13-67.		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR <i>Charles S. Zeiler</i>			ADDRESS CHARLES S. ZEILER FUNERAL HOME		25a. REC'D BY REGISTRAR NOV 13 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
			6200 BLK EASTERN AVE. BALTIMORE, MD.						

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OFFICE OF DEATH

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VETERANS ADMINISTRATION HOSPITAL

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13619

CERTIFICATE OF DEATH

13625

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, Towson, Md. 21204		d. STREET ADDRESS Cedar Lane	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle A. Last SMETANA		4. DATE OF DEATH Month October Day 29 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-1898
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.	11. BIRTHPLACE (County & State, or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Anthony J. Smetana		14. MOTHER'S MAIDEN NAME Frances Solar	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 212-05-5588	
17. INFORMANT Marie A. Smetana - Cedar Lane-Kingsville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO (b) Paralytic ileum DUE TO (c) Left ureteral calculi with chronic pyelonephritis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) this (hospital) attended the deceased from 10-28 , 1967, to 10-29 , 1967, that he (we) last saw the deceased alive on 10-29 , 19 67 and that death occurred at 9:15AM , from causes and on the date stated above.			
22a. SIGNATURE Ines Cilliani, M.D.		22b. DATE SIGNED 10-29-67	
22c. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-2-67	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR John C. Miller Inc. - 6415 Belair Rd. - 21206		25a. REC'D BY REGISTRAR NOV 2 1967	
		25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13620

13626

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN IT 192 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balt. City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21223 d. STREET ADDRESS 2118 W. Saratoga St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence Edward Smith First Middle Last 4. DATE OF DEATH Oct 21 1967 Month Day Year		5. SEX M 6. COLOR OR RACE C 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 10-4-02 9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor 10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Smith		14. MOTHER'S MAIDEN NAME Mary Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-09-0981	
17. INFORMANT Records at Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Myocardial infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 0021 (b) Arteriosclerotic heart disease (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 2-3 mos 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-12 , 1967, to 10-21 , 1967, that (I) (we) last saw the deceased alive on 10-20 , 1967, and that death occurred at 5:45 A , from causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 10-21-67	
22c. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-25-67	
23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR MORTON & Dyer II		25a. REC'D BY REGISTRAR OCT 24 1967	
ADDRESS 1701 LAURENS		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1
FOR STATE
HEALTH DEPT

13621

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13627

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>				c. LENGTH OF STAY IN 1b <u>20 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wiseburg Rd.</u>				d. STREET ADDRESS <u>Wiseburg Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Herbert MILTON SMITH</u>				4. DATE OF DEATH <u>Oct 28</u> 19 <u>67</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 13 1904</u> 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTH PLACE (State or foreign country) <u>Bentley Springs, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel C. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Reba Harris</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>716-12-3356</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>A.M. France</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>A.M. FRANCE</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Oct 31 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Freeland, Md.</u>	
24. FUNERAL DIRECTOR <u>Dr. Karlenslem, New Freedom, Pa.</u>				25a. REC'D BY REGISTRAR <u>OCT 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Richard Judge</u>	

THE STATE
HEALTH DEPT

County of St. Louis, Missouri
County of St. Louis, Missouri

No. 12-3501
Samuel D. Smith
Rick Foreman
M. W.
Dec 13 1904 62
Baltimore, Md

Wassburg Rd
White Hall
Baltimore

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #106 & 16 Film #G394 11/6/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13628

FOR STATE HEALTH DEPT.

13622

Item #14 per teleph conv. w/ funeral home

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital				d. STREET ADDRESS 921 Breezewick Circle			
3. NAME OF DECEASED (Type or print) First Herman Middle O. Last Smith				4. DATE OF DEATH Month 10 Day 28 Year 1967			
5. SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-20-1912	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 28 Hours 19 Min. 67		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Forman				10b. KIND OF BUSINESS OR INDUSTRY Ellicott Electric Machine		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
13. FATHER'S NAME Ira M. Smith				14. MOTHER'S MAIDEN NAME Sara I. Swanner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 9383 215-10-9388		17. INFORMANT Mrs. Doris B. Smith Address 921 Breezewick Circle	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion Sudden DUE TO Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 48 hrs DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.				22. DATE SIGNED 10/28/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11-1-1967		23c. NAME OF CEMETERY OR CREMATORY Fork Meth Cemetery	
23d. LOCATION (City or Town) (County) (State) Fork Md.							
24. FUNERAL DIRECTOR Lassahn Funeral Home				25a. REC'D BY REGISTRAR 36 DATE NOV 1 1967			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13622

13629

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arbutus c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4411 Wilkens Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arbutus d. STREET ADDRESS 4411 Wilkens Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary S. Smith		4. DATE OF DEATH Month Oct. Day 24 , Year 1967	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1870
9. AGE (In years last birthday) 96 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress	11. BIRTHPLACE (County & State, or foreign country) York, Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Mohr	
14. MOTHER'S MAIDEN NAME Rosenberg		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 220-07-7651A		17. INFORMANT Ethel M. Frechette	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arteriosclerotic C.V. Disease 4221 DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1963 to Oct 24, 1967 , that (I) (we) last saw the deceased alive on Oct 24, 1967 , and that death occurred at 6 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John F. Coolahan M.D.		22b. DATE SIGNED 10/26/67	
22c. PHYSICIAN'S NAME (Type) JOHN F. COOLAHAN, M.D.		22d. ADDRESS 4201 WILKENS AVE - 21229	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 27, 1967	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Marie M. Walters		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 27 1967	

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Delaware

Albany

4411 Wilkes Ave.

4411 Wilkes Avenue

Harry J. Smith

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28, 1870

U.S.A.

at home, York, Penna.

at home

Hoschberg

Thomas Holt

220-07-7051A Ethel F. Proctor

No

4110 Wilkes Ave.
Albany

Oct. 27, 1935 New York University

Oct 21 1935
Baltimore City

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Items 23a & 23b File # 3393 10/20/67 kdc										
13624										
13630										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 21204 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney Towson Nursing Home e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin d. STREET ADDRESS Baldwin Mill Road					
3. NAME OF DECEASED (Type or print) First Middle Last Merritt T. Smith					4. DATE OF DEATH Month Day Year XXIX Oct 11 19 67					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1881		9. AGE (In years lost birthday) 86 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmaster			10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.			11. BIRTHPLACE (County & State, or foreign country) Pt. Deposit, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Truman Smith					14. MOTHER'S MAIDEN NAME Joanne Dixon					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 61-284562		17. INFORMANT Dulaney Towson Nursing Home, 111 West Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary occlusion - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease (c) and cerebral vascular accident.										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										
21. I certify that (I) (this hospital) attended the deceased from September 11, 1965 , to 10-11-1967 , that (I) (we) last saw the deceased alive on 10-10-1967 , and that death occurred at 8:45 M, from causes and on the date stated above.										
22a. SIGNATURE Henry L. McCorkle					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct 11 1967			
22c. PHYSICIAN'S NAME (Type) ARCHER FUNERAL HOME					22d. ADDRESS BENSON, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 11, 1967		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial			23d. LOCATION (City or Town) (County) (State) Bel Air Md			
24. FUNERAL DIRECTOR ARCHER FUNERAL HOME					25a. REC'D BY REGISTRAR OCT 17 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

Statement of *[illegible]*

[Faint, mostly illegible text, likely a handwritten statement or report. Some words like "Statement of" and "Bureau of Plant Industry" are visible.]

10-10-10

[Handwritten signature or initials]

[Handwritten text, possibly a name]

[Faint text at the bottom of the page, possibly a date or reference number]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13625

CERTIFICATE OF DEATH

13631

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. LENGTH OF STAY IN 1b Days <u>21204</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Medical Center.</u>				d. STREET ADDRESS <u>1214 Culvert Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>Gertrude</u> Last <u>Snyder.</u>				4. DATE OF DEATH Month <u>10</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>10-17-79</u>		9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>GUFFY-Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa.</u>	
13. FATHER'S NAME <u>Albert Clyde Snyder.</u>				14. MOTHER'S MAIDEN NAME <u>Wm. Jones Rachel Corsin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-36-3403</u>		17. INFORMANT Address <u>Henry W. Jones, Same as # 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular disease accident</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>atherosclerotic cardiovascular disease.</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10.7.67</u> , 19 <u>67</u> , to <u>10.14.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10.13.67</u> 19 <u>67</u> , and that death occurred at <u>5:04</u> M., from causes and on the date stated above.							
22a. SIGNATURE <u>Dipak Kumar Mallik</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10.14.67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DIPAK KUMAR MALLIK</u>				22d. ADDRESS <u>Greater Baltimore Medical Centre.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct.16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Dorsey, Howard Co., Maryland</u>	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204				25a. REC'D BY REGISTRAR <u>OCT 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

1957

Greater Baltimore Medical Center, 1314 Calvert Rd.
Hempstead
Baltimore

Male
Gustaf X
10-15-77
10-17-77
10-17-77

Albert Clyde Snyder
10-31-3403
10-31-3403
10-31-3403

Dipak Kumar Mallik
10-13-67
10-13-67
10-13-67

13632

13626

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 12yr5mth14dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4014 STARBROOK ROAD e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES	
3. NAME OF DECEASED (Type or print) First Rose Middle XXXXXXXXXX Last Sofronsky		4. DATE OF DEATH Month October Day 23 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (County & State, or foreign country) Russia
13. FATHER'S NAME RABBI MENACHUM N. WEISBLATT		14. MOTHER'S MAIDEN NAME Hannah XXXXXXXX ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219-54-3435	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5720 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (x) (this hospital) attended the deceased from April 11 , 19 55 to Oct. 23 19 67 , that (x) (we) last saw the deceased alive on Oct. 23 , 19 67 , and that death occurred at 2:55 P.M. from causes and on the date stated above.			
22a. SIGNATURE Anthony J. Young, M.D.		22b. DATE SIGNED 10-23-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-24-67	23c. NAME OF CEMETERY OR CREMATORY OHR KNESSETH ISRAEL ANSHE SFARD, BALTIMORE, MARYLAND	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD		25a. REC'D BY REGISTRAR OCT 27 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13627

13633

1. PLACE OF DEATH a. COUNTY Baltimore, County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, Md. 21228				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS 4104 Mountwood Road 21229			
3. NAME OF DECEASED (Type or print) Dallas Ora Southworth				4. DATE OF DEATH Oct. 8, 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1885	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Battery man		10b. KIND OF BUSINESS OR INDUSTRY Retired - self		11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Southworth				14. MOTHER'S MAIDEN NAME Lucretia ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 216-10-8770		17. INFORMANT Address Spring Grove Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis + Ca Lung + Brain Metastasis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 11 , 19 67 , to Oct. 8 , 19 67 , that (I) (we) last saw the deceased alive on OCT 8 19 67 , and that death occurred at 7 P M, from causes and on the date stated above.							
22a. SIGNATURE Robert Fisher				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/8/67	
22c. PHYSICIAN'S NAME (Type) Robert Fisher				22d. ADDRESS Spring Grove State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/12/67		23c. NAME OF CEMETERY OR CREMATORY Landon Pk.		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR JOHN T. STANSBURY				ADDRESS 4111 WINDSOR MILL RD. BALTO.		25a. REC'D BY REGISTRAR OCT 11 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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ESTIMATE IN HEAD

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13628

CERTIFICATE OF DEATH

13634

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2410 Harwood Road		d. STREET ADDRESS 2410 Harwood Rd.	
3. NAME OF DECEASED (Type or print) Edward H. Spence		4. DATE OF DEATH Month Oct. Day 1 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1924
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lithographer		10b. KIND OF BUSINESS OR INDUSTRY Printing	
11. BIRTHPLACE (County & State, or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Spence		14. MOTHER'S MAIDEN NAME Margaret Cahill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes		16. SOCIAL SECURITY NO. 993-10-8619	
17. INFORMANT Virginia Spence		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive coronary artery occlusion DUE TO (b) Coronary artery sclerosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 1/2 - 1 hr. ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1963 , to Sept 25, 1967 , that (I) (we) last saw the deceased alive on Sept 25, 1967 , and that death occurred at 2:30 M, from causes and on the date stated above.			
22a. SIGNATURE Theodore J. Graziano		22b. DATE SIGNED Oct 3, 1967	
22c. PHYSICIAN'S NAME (Type) Theodore J. Graziano		22d. ADDRESS 2802 Harford Rd 21218	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF Oct. 4, 1967	
23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR C. F. Evans & Son 8802 Harford Road		25a. REC'D BY REGISTRAR OCT 4 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and fill with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13629

13635

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		
c. LENGTH OF STAY IN 1b <u>14 Yrs</u>			d. STREET ADDRESS <u>3314 Offutt Rd</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Baltimore County General</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence L Stephens</u>			4. DATE OF DEATH Month Day Year <u>10 24 1967</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-83</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Weaver</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Cotton Mill</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>John William Forsythe</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>213 037511</u>		
17. INFORMANT Address <u>Mary Dorothy Meszars 3314 Offutt Rd</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident (THROMBOSIS)</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ATHEROSCLEROSIS, GENERALIZED</u> (e), stating the underlying cause last. } DUE TO (c) <u>Unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arteriosclerotic Heart Disease</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>					
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>10-20</u> , 19 <u>67</u> , to <u>10-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-24</u> , 19 <u>67</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above.					
22a. SIGNATURE <u>Rolando A. Madamba</u> M.D.					
22b. DATE SIGNED <u>10-25-67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Rolando A. Madamba</u>					
22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)					
23b. DATE THEREOF <u>10-27-67</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>Woodburn Cem</u>					
23d. LOCATION (City, town or county) (State) <u>Woodburn Bk Co Md</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Burgee Funeral Home 3631 Falls Rd</u> ADDRESS					
25a. REC'D BY REGISTRAR <u>OCT 30 1967</u>					
25b. REGISTRAR'S SIGNATURE <u>John Charles Jones</u>					

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STATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13630

CERTIFICATE OF DEATH

13636

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hosp.		d. STREET ADDRESS Allison Dr. Carroll Manor	
3. NAME OF DECEASED (Type or print) EDWARD STUDZ		4. DATE OF DEATH Month Oct. Day 9 Year 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 27 1902
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 12 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Real Estate & Ins. Md.	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Karol Studz		14. MOTHER'S MAIDEN NAME Bertha Rybicki	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-30-4094	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) _____ DUE TO (b) German Pottery Disease DUE TO (c) Antacid Induced Cardiac Vasculature Disease			INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12 Nov , 19 67 , to 8 Oct , 19 67 , that (I) (we) last saw the deceased alive on 8 Oct , 19 67 , and that death occurred at 11 PM , from causes and on the date stated above.			
22a. SIGNATURE Howard Goodman		22b. DATE SIGNED 12 Oct 67	
22c. PHYSICIAN'S NAME (Type) HOWARD GOODMAN M.D.		22d. ADDRESS 8604 Harford road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-13-67	23c. NAME OF CEMETERY OR CREMATORY St. John's Long Green	23d. LOCATION (City or Town) (County) (State) Balto Co Md.
24. FUNERAL DIRECTOR C.F. EVANS & SON		25a. REC'D BY REGISTRAR 8802 Harford road	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 16 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0638

Brifmore

Towson

Joseph's House

Edward's Studio

W. L. ...

Real Estate & ...

Karl's Studio

Arthur's Studio

1215-10-1004 Family Records

Handwritten notes:
George ...
William ...

1904

HOWARD BOON ...

10-18-03

C.F. Evans & Son ...

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13631

13637

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST JOSEPH HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH		4. DATE OF DEATH OCT 24 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 3 1881
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCCER SELF		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JOSEPH SWIECZKOWSKY		14. MOTHER'S MAIDEN NAME JOSEPHINE ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 018-18-2034A	
17. INFORMANT ROSE SWISS		Address 6232 BELAIR RD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden DUE TO Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Subarachnoid DUE TO Fracture of Rt Hip (c) 5 Day		INTERVAL BETWEEN ONSET AND DEATH 5 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall down Steps on own Home	
20c. TIME OF INJURY Month, Day, Year 12 19 1967 Hour 10 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Baltimore City (County) MD (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		22. DATE SIGNED 10/25/67	
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF OCT 27 1967	23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEM.	23d. LOCATION (City or Town) GERMAN HILL RD BALTIMORE (County) (State)
24. FUNERAL DIRECTOR THE DIPPEL BROS INC 7110 BELAIR RD.		25a. REC'D BY REGISTRAR OCT 26 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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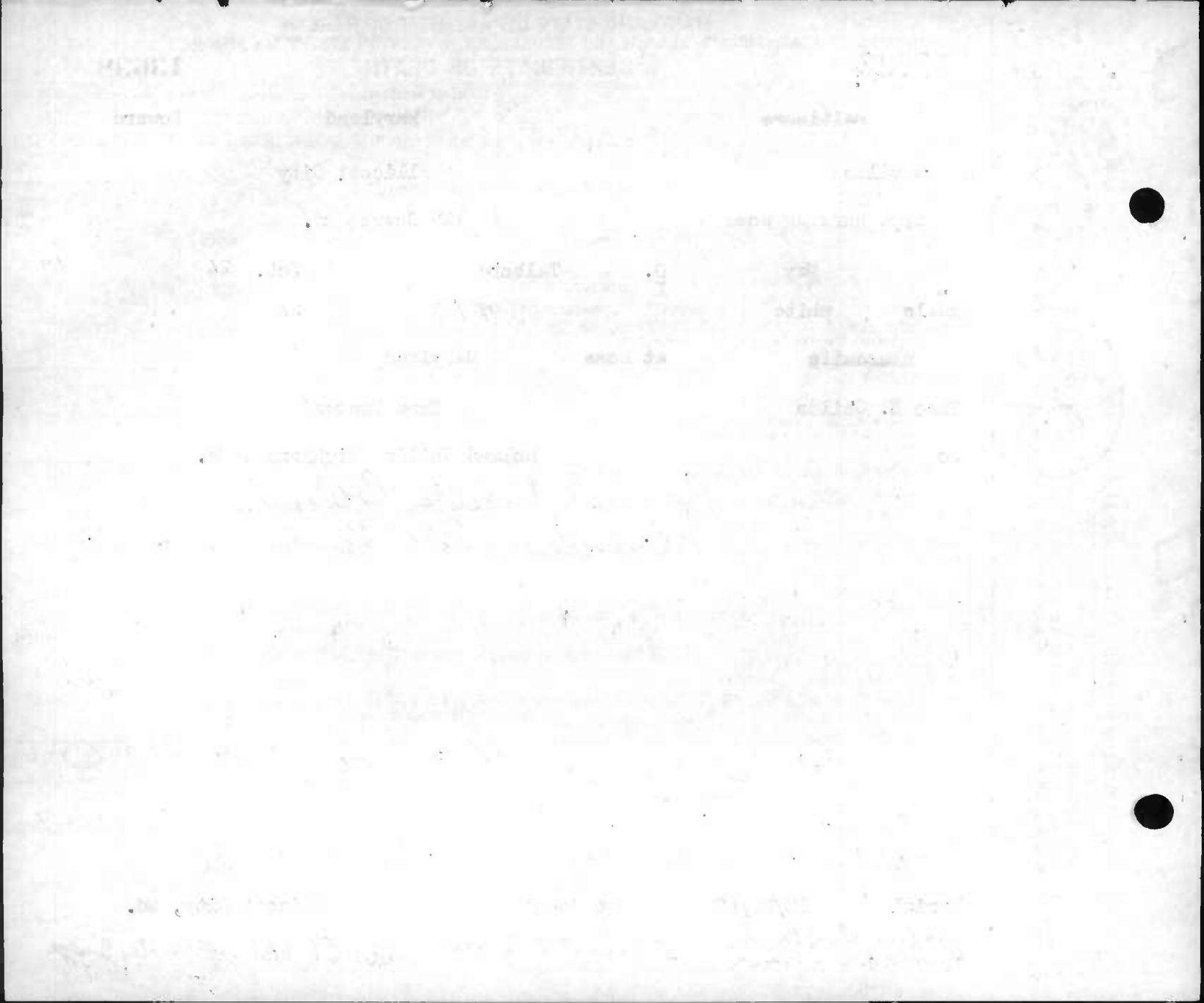
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carb. in pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13632
CERTIFICATE OF DEATH
13638

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Summit Supt. Nursing home		d. STREET ADDRESS 127 Church Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Way G. Talbott		4. DATE OF DEATH Oct. 24 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home	9. AGE (in years last birthday) 84 yrs.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theo E. Childs		14. MOTHER'S MAIDEN NAME Emma Umstead	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Roland Childs Highland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericardial Vascular Collapse 4221 DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 10yr		INTERVAL BETWEEN ONSET AND DEATH 10yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-14 , 19 61 , to 10-24 , 19 67 , that (I) (we) last saw the deceased alive on 10-23 , 19 67 , and that death occurred at 3 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas P. Herbert		22b. DATE SIGNED 10-24-67	
22c. PHYSICIAN'S NAME (Type) Thomas P. Herbert, MD		22d. ADDRESS Ellicott City, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 10/26/67	23c. NAME OF CEMETERY OR CREMATORY St Johns	23d. LOCATION (City, town or county) (State) Ellicott City, Md.
24. FUNERAL DIRECTOR John C. Slack Hginbelhon - Slack		25a. REC'D BY REGISTRAR OCT 27 1967	
ADDRESS Ellicott City Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13639

13633

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			<u>03-1</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summitt Nursing Home</u>				d. STREET ADDRESS <u>1814 Colonial Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>E.</u> Last <u>Thalheimer</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1892</u>		9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herman Bennett</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Saffran</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Elizabeth Thalheimer</u> <u>1814 Colonial Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>10 years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>TERMINAL BRONCHITIS PNEUMONIA & CHRONIC BRONCHITIS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 30, 1967</u> , to <u>October 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>October 9, 1967</u> , and that death occurred at <u>3:27 AM</u> , from causes <u>as stated</u> on the date stated above.							
22a. SIGNATURE <u>Melvin N. Borden</u>				22b. DATE SIGNED <u>10/10/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Melvin N. Borden, M. D.</u>	
22d. ADDRESS <u>5000 Baltimore National Pike 21224</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Av.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1943

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 403 N. WOODWARD DR.		d. STREET ADDRESS 403 N. WOODWARD DR.	
3. NAME OF DECEASED (Type or print) First BARBARA Middle C. Last THOMAS		4. DATE OF DEATH Month OCT Day 11 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 19, 1884
9. AGE (In years lost birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 03 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES JAMES		14. MOTHER'S MAIDEN NAME PAULINE SCHMIDT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT WM. R. THOMAS JR.		Address 7105 EASTERN AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-Disease 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility (c) —		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/13/67	
23c. NAME OF CEMETERY OR CREMATORY LORRAINE		23d. LOCATION (City or Town) (County) (State) BALTO. MD.	
24. FUNERAL DIRECTOR J. G. CONNELLY SRMS		25a. REC'D BY REGISTRAR 300 MACE	
25b. REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 10/13/67	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13641

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville, Md.</i>		c. LENGTH OF STAY IN 1b <i>8 yrs 6 mo.</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Md.</i>		304	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Masonic Home</i>		d. STREET ADDRESS <i>3603 Old York Rd.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>CLARINDA L. S. THOMAS</i>		4. DATE OF DEATH Month Day Year <i>Oct. 21 1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 13, 1881</i>
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Balto, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Seipp</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Moore</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>214-03-5088</i>	
17. INFORMANT <i>Masonic Home Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO <i>Recurrent cerebrovascular accident</i> (b) <i>Advanced Senility</i> DUE TO <i>3. Multiple secretory ulcers</i> (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>August 15, 1965</i> to <i>Oct 20, 1967</i> , that (I) (we) last saw the deceased alive on <i>Oct 20, 1967</i> , and that death occurred at <i>6:30 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>JAMES H. HAMED, M.D.</i>		22b. DATE SIGNED <i>10/21/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES H. HAMED</i>		22d. ADDRESS <i>MASONIC HOME</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>10-23-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge</i>	23d. LOCATION (City or town) (County) (State) <i>Cockeysville, Md.</i>
24. FUNERAL DIRECTOR <i>Wm. C. Brooks Towson</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>OCT 26 1967</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13636

CERTIFICATE OF DEATH

15125

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Maryland			c. LENGTH OF STAY IN 1b lyr6mty3dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City #21230		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS 1014 Leadenhall Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George Albert Thomas				4. DATE OF DEATH Month Day Year October 21 19 67			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 3, 1894		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Arron Thomas				14. MOTHER'S MAIDEN NAME Martha			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) None		16. SOCIAL SECURITY NO. 215-03-9787		17. INFORMANT Address Records: Spring Grove State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, diaphragmatic 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic cardiovascular Ht. Dis. DUE TO (c) 10 years						INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchopneumonia, terminal, organism unk./congestive Ht. Fail.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 18, 1966 to Oct. 21, 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 21 19 67 , and that death occurred at 7:15 P., from causes and on the date stated above.							
22a. SIGNATURE <i>Anthony J. Young</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-23-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.				22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/26/67		23c. NAME OF CEMETERY OR CREMATORY Northlawn		23d. LOCATION (City or Town) (County) (State) Baltimore City	
24. FUNERAL DIRECTOR J.H. Brown 108 W. Montgomery &				25a. REC'D BY REGISTRAR DATE NOV 10 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 2 (M) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY BALTIMORE CITY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 446 TURMAN COURT e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EMILY THOMPSON		4. DATE OF DEATH Month Day Year 10 - 29 - 1967	
5. SEX F.	6. COLOR OR RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-23-1900
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Morris Hill, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Williams		14. MOTHER'S MAIDEN NAME Millie Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Records at Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCT. 26 , 1967, to OCT. 24 , 1967, that (I) (we) last saw the deceased alive on 19 , and that death occurred at 12:30 A.M. , from causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 10-29-67	
22c. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-1-67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cmt.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Randolph J. Collick		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 31 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13638

CERTIFICATE OF DEATH

13643

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORT HOWARD			c. LENGTH OF STAY IN 1b 9 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 524 GORSUCH AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last VINCENT JAMES JOSEPH TORTORO				4. DATE OF DEATH Month Day Year OCTOBER 29 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 27, 1899		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) COBLESKILL, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BIAGIO TORTORO				14. MOTHER'S MAIDEN NAME ANTOINETTE TROTTEA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 219-32-2995		17. INFORMANT Address CLINICAL RECORDS, VAH, FT. HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY CONGESTION AND EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOPNEUMONIA (c) SCROTAL ABSCESSSES, BILATERAL INCISED AND DRAINED							INTERVAL BETWEEN DEATH AND DEATH RECENT RECENT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that he (this hospital) attended the deceased from OCT 10 , 19 67 , to OCT 29 , 19 67 , that he (we) last saw the deceased alive on OCT 29 , 19 67 , and that death occurred at 6:05AM , from causes and on the date stated above.							
22a. SIGNATURE <i>George C. McElPatrick</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/30/67	
22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11-2-67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		25a. REG'D BY REGISTRAR NOV 1 1967	
24. FUNERAL DIRECTOR		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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DEPARTMENT OF DEAN

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VERMONT ADMINISTRATION HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items #2c & d #11-#0391 11/2/67 ph											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21212</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>						d. STREET ADDRESS <u>189 E. Gittings Ave.</u> <u>Pickettsburg Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arnie</u> Middle <u>Townshend</u> Last						4. DATE OF DEATH Month <u>10</u> - Day <u>26</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-9-77</u>		9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John S. Townshend</u>						14. MOTHER'S MAIDEN NAME <u>Mary ?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-20-2074</u>		17. INFORMANT Address <u>Nursing Home Records, Towson, Md. 21204</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) <u>Arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>Cerebro-vascular accident</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebro-vascular accident</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>p.m.</u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10-25</u> , 19 <u>67</u> , to <u>10-26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-26</u> , 19 <u>67</u> , and that death occurred at <u>11:20 PM</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>Jose M. de Leon, M.D.</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>10-26-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSE M. DE LEON, M.D.</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Oct. 30, 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		23d. LOCATION (City or Town) (County) (State) <u>Woodlawn, Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Towson, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>OCT 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1914

REPORT OF THE

[Faint, illegible text covering the main body of the page, likely a report or memorandum.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13640

13645

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sue Avenue - S. of Turkey Point Rd.		d. STREET ADDRESS 1632 N. Bond St.	
3. NAME OF DECEASED (Type or print) GUY		4. DATE OF DEATH October 30, 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-19 25
9. AGE (In years lost birthdate) yrs. 42		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR	
11. BIRTHPLACE (State or foreign country) Tillar, Ark		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME GUY TUCKER		14. MOTHER'S MAIDEN NAME IONIA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW#2		16. SOCIAL SECURITY NO. 432-34-5745	
17. INFORMANT ANNIE TUCKER		Address 1632 N. Bond	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently shot during robbery	
20c. TIME OF INJURY Month, Day, Year UNK Hour a.m. 10/30/67 p.m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Baltimore, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz		22. DATE SIGNED 10/31/67	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		22. DATE SIGNED 10/31/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/3/67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cem.		23d. LOCATION (City or Town) (County) (State) 5501 Fred'k Ave.	
24. FUNERAL DIRECTOR Milton E. E. E. E. E.		25a. REC'D BY REGISTRAR NOV 1 1967	
25b. REGISTRAR'S SIGNATURE James Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 86 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 5209 IVANHOE AVENUE	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle CHRISTOPHER Last VALENTINE		4. DATE OF DEATH Month OCTOBER Day 15 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/23/98
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUTCHER		10b. KIND OF BUSINESS OR INDUSTRY MEAT	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CONRAD VALENTINE		14. MOTHER'S MAIDEN NAME HANNAH BACHMANN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 213 10 34 73	
17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) POST OPERATIVE STATUS POST PROSTECTOMY DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE WITH MYOCARDIAL SCARRING. ENCEPHALOMALACIA INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from 7/23/67 , to 10/15/67 , 19__, that he (we) last saw the deceased alive on 10/15/67 , 19__, and that death occurred at 7:20AM from causes and on the date stated above.			
22a. SIGNATURE Joseph J. Mowad		22b. DATE SIGNED 10/16/67	
22c. PHYSICIAN'S NAME (Type) JOSEPH J. MOWAD, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-19-67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR EVANS FUNERAL HOME		25a. REC'D BY REGISTRAR Oct 17 1967	
ADDRESS 8802 HARFORD RD. BALTIMORE, MD.		DATE 10/17/67	

REGISTRAR'S SIGNATURE
James Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13642

CERTIFICATE OF DEATH

13647

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 281 VANDERMAST LANE				d. STREET ADDRESS 281 VANDERMAST LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARIE M. VANDERMAST				4. DATE OF DEATH OCT. 31 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 2, 1880		9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARNOLD VANDERMAST				14. MOTHER'S MAIDEN NAME ELIZABETH HERR			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Address EDNA VANDERMAST ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO-SCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 2 YRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) VIRAL UPPER RESPIRATORY INFECTION							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from SEPT. 23, 1965 , to OCT 31, 1967 , that (I) (we) last saw the deceased alive on OCT 30 19 67 , and that death occurred at 11:30 AM , from causes and on the date stated above.							
22a. SIGNATURE Joseph Miceli				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/1/67	
22c. PHYSICIAN'S NAME (Type) JOSEPH MICELI, M.D.				22d. ADDRESS 108 S. TAYLOR AVE. ESSEX, MD. 21221			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 3, 1967		23c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE		23d. LOCATION (City or Town) (County) (State) BALTO. MD.	
24. FUNERAL DIRECTOR J. S. CONNELLY SONS				ADDRESS 300 MACE		25a. REC'D BY REGISTRAR DATE NOV 6 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 500 Nicoll Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Benardus Middle Van Der Wensch Last Oct.		4. DATE OF DEATH Month 16, Day 19 Year 67							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH Sept. 3, 1878		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 89 Days 89					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Holland					
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Lucille D. Weyrauch 3508 Jean Drive					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) 231X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 hour				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from 10/6, 1967 to 10/16, 1967, that (I) (we) last saw the deceased alive on 10/9, 1967, and that death occurred at 1:45 M, from the causes and on the date stated above.									
22a. SIGNATURE Robert A. Reiter				22b. DATE SIGNED 10/17/67					
22c. PHYSICIAN'S NAME (Type) Robert A. Reiter, M.D.				22d. ADDRESS 606 Edmonstone Ave 212 28					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-1967		23c. NAME OF CEMETERY OR CREMATORY Camp Chapel Bath Church					
23d. LOCATION (City, town or county) Brooklyn		(State) Md.		25a. REC'D BY REGISTRAR					
24. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave.,		25b. REGISTRAR'S SIGNATURE OCT 17 1967							

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>804 Stevenson Lane</u>		d. STREET ADDRESS <u>804 Stevenson Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Genevieve Freeman Walck</u>		4. DATE OF DEATH Month Day Year <u>October 14 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1896</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliver Freeman</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Barrett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> <u>yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan.</u> , 19 <u>66</u> , to <u>October 14</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 10</u> 19 <u>67</u> , and that death occurred at <u>7 a</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>A. J. Venable, Jr. M.D.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10-16-67</u>
22c. PHYSICIAN'S NAME (Type) <u>S. J. Venable, Jr. M.D.</u>		22d. ADDRESS <u>7215 York Road, Baltimore, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-17-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Paxtang Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Paxtang Pennsylvania</u>
24. FUNERAL DIRECTOR <u>John Burns Sons Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 19 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>5 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House in the Pines</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>5TH E. FORT AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FANNIE WALSH</u>			4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1967</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/25/1883</u>		9. AGE (In years last birthday) <u>84</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>ENGLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>ALBERT SMITH</u>				
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				
16. SOCIAL SECURITY NO. <u>215 05 535TD</u>			17. INFORMANT <u>MRS. EILEEN HELLMAN</u> Address <u>5406 Summerfield Ave.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>1537</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>4-17</u> , 19 <u>68</u> , to <u>10-16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-14</u> , 19 <u>67</u> , and that death occurred at <u>3:30</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Wilmer K. Gallagher</u>			22b. DATE SIGNED <u>10/17/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		
22d. ADDRESS <u>6209 Frederick Ave. Balt. Md 21228</u>			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie AA Md.</u>	25a. REC'D BY REGISTRAR <u>DA OCT 19 1967</u>			
24. FUNERAL DIRECTOR <u>M. Kelly</u> ADDRESS <u>130 E. Fort Avenue</u>			25b. REGISTRAR'S SIGNATURE <u>g Charles Judge</u>				

13650

REMARKS OF DEATH

John
Cassidy
Died at his home
in the city of New York

10/1/13

John Cassidy
Died at his home
in the city of New York

10/1/13

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13646

13651

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>753</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Anneslie 21212</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mbnessen</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>804 Maxalea Court</u>				d. STREET ADDRESS <u>207 Schell Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>T.</u> Last <u>Wanko</u>				4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 6, 1895</u>		9. AGE (In years last birthday) yrs. <u>71</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Guard-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Plant</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Wanko</u>				14. MOTHER'S MAIDEN NAME <u>Margaret ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Family records</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Renal</u> DUE TO <u>5 yr</u> (c) <u>Vascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
			Address (Street, city, town, or county) <u> </u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal/Burial</u>		23b. DATE THEREOF <u>Oct. 23, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Belle Vernon Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>N. Belle Vernon, Penna.</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>				25a. RECEIVED BY REGISTRAR <u>OCT 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

13652

13647

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN It 03.1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		d. STREET ADDRESS 6402 Blenheim Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Richardson WEBSTER		4. DATE OF DEATH Month Day Year Oct. 7, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-62
9. AGE (In years lost birthday) 5 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. BIRTHPLACE (County & State, or foreign country) Baltimore City, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James McCormick Webster	
14. MOTHER'S MAIDEN NAME Nancy Jane Menton		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no --	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Rosewood Records, Owings Mills, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) tracheo-bronchial obstruction DUE TO 490x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) neurosis DUE TO Klebsiella Pneumonia (c) 1 month			INTERVAL BETWEEN ONSET AND DEATH hrs. wks 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	22d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	22f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1967 to Oct. 7, 1967 that (I) (we) last saw the deceased alive on Oct. 7, 1967 , and that death occurred at 11A M, from causes and on the date stated above.			
22a. SIGNATURE Richard A Jones		22b. DATE SIGNED 7 Oct, 67	
22c. PHYSICIAN'S NAME (Type) Richard A Jones M.D.		22d. ADDRESS Rosewood State Hosp.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF Oct. 10, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Govan's	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		25a. REC'D BY REGISTRAR OCT 11 1967	
ADDRESS 6500 York Road		25b. REGISTRAR'S SIGNATURE [Signature]	
Balto., Md. 21212			

CONFIDENTIAL

TO THE
FROM
SUBJECT
DATE
RE

Enclosed
Klaus F. J. J.

[Signature]
G. H.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13653

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Plant Dispensary		d. STREET ADDRESS 119 N. Symington Ave.	
3. NAME OF DECEASED (Type or print) First Charles Middle J. Last WEDEKIND		4. DATE OF DEATH Month 10 Day 18 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-1918
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 10 Days 18 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10b. KIND OF BUSINESS OR INDUSTRY Steel Making	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Md.	
13. FATHER'S NAME Charles J. Wedekind		14. MOTHER'S MAIDEN NAME Carrie Price	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-1118	
17. INFORMANT Charles J. Wedekind		Address 119 N. Symington Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH one (1) hr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> N CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) O N	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis EXAMINER'S NAME (Type) M. B. Davis, M.D. 6800 Morningside Rd		22. DATE SIGNED 10-18-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-21-67	
23c. LOCATION (City or Town) (County) (State) Baltimore Md.		23d. REC'D BY REGISTRAR Charles Judge	
24. FUNERAL DIRECTOR Fairley-Cromarty D.F.H. - Catonsville, Md.		25. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13649 Item #4 Film #G393 10/11/67 ph									
CERTIFICATE OF DEATH									
13654									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY J				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			304	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital					d. STREET ADDRESS 917 North Kresson Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Doris V. Wehrheim					4. DATE OF DEATH Month Oct. Day 9 Year 19 67				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 3, 1921		9. AGE (In years last birthday) 46 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File Clerk		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Henry Wehrheim					14. MOTHER'S MAIDEN NAME Minnie VanSant				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 217142021		17. INFORMANT Records: Spring Grove State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 490X IMMEDIATE CAUSE (a) Lobar Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Brain Tumor								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 28 , 19 42 , to Oct 9 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct 9 , 19 67 , and that death occurred at 7:45 M, from causes and on the date stated above.									
22a. SIGNATURE Stella Wachsler					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.					22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10/11/67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane					25a. REC'D BY REGISTRAR DATE OCT 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13650

13655

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>J</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE CITY - 21213-30-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>3307 ELMORA</u>	
3. NAME OF DECEASED (Type or print) <u>MARY MATTHEWS WELLS</u>		4. DATE OF DEATH Month <u>10</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/1898</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE CITY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM BELTMAN</u>		14. MOTHER'S MAIDEN NAME <u>FRANKLIN, ROSE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Admission Sheet</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lympho Sarcoma</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/6/1967</u> to <u>10/25/1967</u> , that (I) (we) last saw the deceased alive on <u>10/25/1967</u> , and that death occurred at <u>8:20 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Abthian</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>Abthian</u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-28-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Elkridge, Maryland</u>	
24. FUNERAL DIRECTOR <u>John C. Miller Inc. - 6415 Belair Road - 21206</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 31 1967</u>	

1980

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth	
John Doe		1925-01-15	
Sex		Age	
Male		55	
Race		Marital Status	
White		Married	
Place of Birth		Date of Death	
Chicago, Ill.		1980-03-10	
Cause of Death		Place of Death	
Heart Disease		Home	
Physician's Signature		Signature of Informant	
[Signature]		[Signature]	
Date of Certificate		Registrar's Signature	
1980-03-15		[Signature]	

1
3
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13651					13656				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson Baltimore</u>			c. LENGTH OF STAY IN 1b <u>35 Days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21236</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>					d. STREET ADDRESS <u>8219 Belair Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>VIVIAN</u>		First <u>JULIA</u>		Middle <u>WELLS</u>		Last		4. DATE OF DEATH Month <u>October</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>3/21/1899</u>		9. AGE (In years last birthday) <u>68</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Budapest, Hungary</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Joseph Janosek</u>				14. MOTHER'S MAIDEN NAME <u>Anna Lehotsky</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-07-0190</u>		17. INFORMANT <u>J.M. Boyd, Jr., 706 Stevenson Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ileocolic fistula and perforated duodenal ulcer</u> DUE TO (c) <u>Post-operative-state - Resection of aneurysm of abdominal aorta</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>September 7, 1967</u> to <u>October 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>October 13, 1967</u> , and that death occurred at <u>4:40 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>John E. Adams</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> AM MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>10/13/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>John E. Adams, M.D.</u>				22d. ADDRESS <u>Greater Baltimore Med. Center</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>10/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>		
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u>				25a. REC'D BY REGISTRAR <u>OCT 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10000



W. J. 100

Handwritten signature or initials.

10000

10000

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13652

15139

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarm d. STREET ADDRESS Notchcliff - Villa Maria e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sister Orosa Mary Wernsdorfer First Middle Last				4. DATE OF DEATH October 29, 1967 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 20, 1881	
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER				10b. KIND OF BUSINESS OR INDUSTRY EDUCATION		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Not Known				14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. Not Known		17. INFORMANT Convent Records Address VILLA MARIA, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Pulmonary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic cardiovascular Vascular disease DUE TO 10 yrs (c) Ischemic heart disease Fracture left hip DUE TO 4 Days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Fracture of Left Hip							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fall out of Chair onto floor			
20c. TIME OF INJURY Month, Day, Year 2:45 a.m. 10/26/67		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Notchcliff (County) Glenarm (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell M.D. EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.				22. DATE SIGNED 30/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT 31, 1967		23c. NAME OF CEMETERY OR CREMATORY SISTERS CEMETERY		23d. LOCATION (City or Town) GLEN ARM (County) MARYLAND (State)	
FUNERAL DIRECTOR RAYMOND J CURRAN ADDRESS 817 SCARLETT DR TOWSON, MD. 21204				25a. REC'D BY REGISTRAR NOV 14 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jones	

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13653

CERTIFICATE OF DEATH

13657

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>		c. LENGTH OF STAY IN <u>1 month</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shangri-la Nursing Home</u>		d. STREET ADDRESS <u>8040 Philadelphia Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Katherine E. Wheeler</u>		4. DATE OF DEATH <u>10/29</u> 19 <u>67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/95</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown Jacob WEBER</u>		14. MOTHER'S MAIDEN NAME <u>Unknown MYERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT <u>Hosp. Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> DUE TO <u>332x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO <u>30yrs</u> (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/24</u> , 19 <u>67</u> , to <u>10/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/28</u> , 19 <u>67</u> , and that death occurred at <u>5:45 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>David E. Zickfoose</u>		22b. DATE SIGNED <u>10/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>David E. Zickfoose</u>		22d. ADDRESS <u>4 VFW Lane, Ellicott City, md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/31/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO MD.</u>	
24. FUNERAL DIRECTOR <u>E.S. MALVABB 301 FREDERICK RD 21228</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 1 1967</u>	

1963

STATE OF TEXAS

1963

Blank form area with faint horizontal lines and a large circular stamp on the left side.



Vertical text on the right margin, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13854 Item #9 Film #G394 11/1/67ph											
CERTIFICATE OF DEATH 13638											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>						c. LENGTH OF STAY IN 1b <u>BALTIMORE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1209 ST. AGNES LANE</u>						d. STREET ADDRESS <u>1209 ST. AGNES LANE</u>					
3. NAME OF DECEASED (Type or print) First <u>EDGAR</u> Middle <u>EUGENE</u> Last <u>WHITE</u>						4. DATE OF DEATH Month <u>OCT.</u> Day <u>25</u> Year <u>1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAUC.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 13, 1885</u>		8. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERGYMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Blackburg S.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jos. White</u>						14. MOTHER'S MAIDEN NAME <u>MARGAROT SHARP</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>141-22-5665</u>		17. INFIRMANT Address <u>EDGAR E. WHITE JR. 1209 ST AGNES LANE</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Rt Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>2 yr.</u>	
PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 19, 1966</u> to <u>Oct 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 25, 1967</u> , and that death occurred at <u>1030 M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>John N. Snyder</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/25/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN N. SNYDER M.D.</u>						22d. ADDRESS <u>6348 FREDERICK RD CATONSVILLE MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>				23b. DATE THEREOF <u>10/26/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LAUREL HILL</u>		23d. LOCATION (City, town or county) (State) <u>Phila, PA.</u>			
24. FUNERAL DIRECTOR <u>WM COOK-BROOKS INC 1217 ST. PAUL ST.</u>						25a. REC'D BY REGISTRAR DATE <u>OCT 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

THE UNIVERSITY OF CHICAGO
LIBRARY

OCT 30 1963

Vol. 10, No. 1, 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

13655

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13659

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. LENGTH OF STAY IN 1b 2 mos 13 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital	
d. STREET ADDRESS Texas, Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle WHYE Last WHYE		4. DATE OF DEATH Month 10 Day 23 Year 1967	
5. SEX M.	6. COLOR OR RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/9/1919
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months 10 Days 23 Hours 19 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labner		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Whye		14. MOTHER'S MAIDEN NAME Annabele Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-05-0263	
17. INFORMANT Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, 1621 DUE TO 2 METASTASES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/10/1967 , to 10/23/1967 , that (I) (we) last saw the deceased alive on 10/23/1967 , and that death occurred at 5 A.M. , from causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-26-67	23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l Cem.	23d. LOCATION (City or Town) (County) (State) Balto. Md
24. FUNERAL DIRECTOR Morton E. Dyett-Fitt		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS 1701 Laurens St.		DATE OCT 24 1967	

DOI: 10.1002/for

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>504 Brook Road</u>		d. STREET ADDRESS <u>504 Brook Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Alma</u> Last <u>Wickman</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-1890</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>03</u> Days <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernst Domeschke</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina -- Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-14-7366D</u>	
17. INFORMANT <u>Ruth Chelf, 504 Brook Rd.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the bladder (transitional cell)</u> <u>1810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Approx 1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>October 20, 1966</u> , to <u>10/2</u> , 1967, that (I) (we) last saw the deceased alive on <u>9/29</u> 1967, and that death occurred at <u>11 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Walter Smyth, M.D.</u>		22b. DATE SIGNED <u>Oct 2, 1967</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>10-5-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Wilmington -- Unknown

211-1-1000 1000 Brook Rd.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13657 Item #2d Film #394 10/31/67 ph					13661				
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 1002 N. Rolling Rd. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 2102 Drummon Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Maude O. Wiest			4. DATE OF DEATH 10 18 19 67		5. SEX Female				
6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/11/82		9. AGE (in years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? usa		
13. FATHER'S NAME George Miller				14. MOTHER'S MAIDEN NAME Mary E. Robey					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 214-22-3512		17. INFORMANT Mr. Russell Miller 15 Oberlin Ct. Balt, Md. 4				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alcohol - acute cardiac vascular disease 422.1x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Pulmonary Disease								INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1963 , to Oct 18, 1967 , that (I) (we) last saw the deceased alive on Oct 17, 1967 , and that death occurred at 8 P. M. from the causes and on the date stated above.									
22a. SIGNATURE J. Nelson McRay				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/20/67			
22c. PHYSICIAN'S NAME (Type) J. Nelson McRay				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/21/67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town or county) (State) Balt, Md.			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc. Balt. Md. 4				25a. REC'D BY REGISTRAR OCT 26 1967		25b. REGISTRAR'S SIGNATURE John Charles Judge			

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13658									
13662									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTO</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(Rural) White Hall</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wesley</u> Last <u>William</u>			4. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>19 67</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/20/47</u>		9. AGE (In years last birthday) <u>20</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Patient's Chart</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic carcinoma to lungs</u> DUE TO (c) <u>Carcinomatosis, primary site undetermined</u>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/16</u> , 1967, to <u>10/11</u> , 1967, that (I) (we) last saw the deceased alive on <u>10/11</u> 1967, and that death occurred at <u>1:50M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>John E. Adams</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. am. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>John E. Adams, M.D.</u>					22d. ADDRESS <u>6701 N. Charles Street</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-14-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cmt.</u>		23d. LOCATION (city, town or county) (State) <u>Anne Arundel Co. Md.</u>			
24. FUNERAL DIRECTOR <u>Randolph J. Collick</u>					ADDRESS <u>2431 E. Oliver St.</u>		25a. REC'D BY REGISTRAR <u>OCT 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13659

CERTIFICATE OF DEATH

13663

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 99 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA		d. STREET ADDRESS OLD MILL RD, BOX #25, RFD #4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLINTON Middle LEE Last WILLIAMS		4. DATE OF DEATH Month OCTOBER Day 28 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/11/96
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY DRY GOODS	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY J. WILLIAMS		14. MOTHER'S MAIDEN NAME JANE PHILLIPS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 214 38 81 61	
17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOGENIC CARCINOMA RIGHT LUNG DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) EMPHYSEMA, LUNGS. ARTERIOSCLEROTIC HEART DISEASE		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from JULY 21, 1967 to OCT 28, 1967 , that he (we) last saw the deceased alive on OCT 28, 1967 , and that death occurred at 8:00PM , from causes and on the date stated above.			
22a. SIGNATURE <i>George Dudas</i>		22b. DATE SIGNED 10/30/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1 Nov 67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR KIRKLEY FUNERAL HOME		25a. REC'D BY REGISTRAR NOV 1 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

ANNE ARUNDEL

MARYLAND

BALTIMORE

PADAMBA

22 DAYS

FORT HOWARD

OLD MILL RD, BOX 422, FPO 41

VETERANS ADMINISTRATION HOSPITAL

63

OCTOBER 28

WILLIAMS

MR

CLINTON

X

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2/11/66

WHITE

MALE

U.S.A.

CUMBERLAND, MARYLAND

MR GOOD

HALEMAN

JAMES WILLIAMS

HENRY J. WILLIAMS

214 38 81 61 CLINICAL RECORDS, VAS, FT. HOWARD, MD.

WAS

RESIDENT

HEMOGLOBIN

UNKNOWN

UNKNOWN TO CARRIAGE, NIGHT LINE

2 P.M. LUNCH. ARTHUR WILLIAMS TO BEAT MESSAGE

63

OCT 28

6:00

JULY 23

OCT 28

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10/30/67

AND FORT HOWARD, MARYLAND

GRAND FURN, N. D.

BALTIMORE, MARYLAND

BALTIMORE, MARYLAND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13650

13664

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 219 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - 21216 d. STREET ADDRESS 2016 RUXTON AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOMER Middle C. Last WILLIAMS		4. DATE OF DEATH Month OCTOBER Day 8 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/93
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY FOOD MARKET	9. AGE (In years last birthday) 74 yrs. Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) AUGUSTA COUNTY, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT WILLIAMS		14. MOTHER'S MAIDEN NAME HANNAH WALKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW I		16. SOCIAL SECURITY NO. 218 05 56 88	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS, FAR ADVANCED, ACTIVE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC BRAIN SYNDROME, CLINICAL. DIABETES MELLITUS, CLINICAL		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) <input checked="" type="checkbox"/> this hospital attended the deceased from 3/3/67 , 19__ to 10/8/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/8/67 , 19__, and that death occurred on 9:10A , from causes and on the date stated above.			
22a. SIGNATURE Peter V. Juvan		22b. DATE SIGNED 10/9/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-11-67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR MORTEN & DYETT FUNERAL HOME		25. REC'D BY REGISTRAR 11 1967	
ADDRESS E. LAURENS ST. BALTIMORE, MD.		25b. REGISTRAR'S SIGNATURE [Signature]	

1-10-51

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WILLIAM - SILENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13661

CERTIFICATE OF DEATH

13665

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 20 Murdock Rd.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 20 Murdock Rd.	
3. NAME OF DECEASED (Type or print) First Leonard Middle C. Last Wilson		4. DATE OF DEATH Month 10 Day 18 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 18, 1897
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 03 Days 1	
IF UNDER 24 HRS. Hours 19 Min. 67		11. BIRTHPLACE (County & State, or foreign country) Ottawa, Canada	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired accountant		10b. KIND OF BUSINESS OR INDUSTRY Can Co	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME John Wilsonn	
14. MOTHER'S MAIDEN NAME UNK.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 108 10 1511		17. INFORMANT Mrs. Violette J. Wilson Address 20 Murdock Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CVD DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH MINUTES 4RS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis & Rt hemiplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN , 19 65 , to OCT 18 , 19 67 , that (I) (we) last saw the deceased alive on OCT 18 , 19 67 , and that death occurred at 11:30 M. from causes and on the date stated above.			
22a. SIGNATURE A. Tenable		22b. DATE SIGNED 10-18-67	
22c. PHYSICIAN'S NAME (Type) S. J. YENABLE JR M.D		22d. ADDRESS 7215 YORK RD. BALTIMORE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/21/1967	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR Mitchell Wiedefeld Address Home 6500 York Rd		25a. REC'D BY REGISTRAR DATE OCT 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1980

UNITED STATES OF AMERICA

1980

Handwritten notes and signatures, including "J. Edgar Hoover" and "FBI".

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Vertical text on the right margin, possibly a date or reference number.

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FOR STATE HEALTH DEPT. 13662

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13666

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Howard c. LENGTH OF STAY IN 1b Essex (21) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fort Howard Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21) d. STREET ADDRESS 215 A. Woodvale Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM A. WILSON, JR		4. DATE OF DEATH Month Day Year October 31, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1895
9. AGE (In years last birthday) yrs. 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationery Engineer	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A. Wilson		14. MOTHER'S MAIDEN NAME Nancy E. Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 213 07 0310A	
17. INFORMANT Margaret McWilliams		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Embolism 9097 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of left hip			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell and sustained injury to left hip	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 9/1/ 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work Nursing Home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Baltimore, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type)		22. DATE SIGNED 10/31/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/4/67	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Prudzinski Funeral Home 1407 Eastern Ave.		25a. REC'D BY REGISTRAR DATE Nov 2 1967	
		25b. REGISTRAR'S SIGNATURE f Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 7844 Rockbourne Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary Lou C Winterling 4. DATE OF DEATH 10 17 1967						5. SEX Female 6. COLOR OR RACE Cau. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 2/22/30 9. AGE (In years last birthday) 37 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary 10b. KIND OF BUSINESS OR INDUSTRY Maryland Title 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Edward Finnerty 14. MOTHER'S MAIDEN NAME Lillian Foll							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 212-28-8696 17. INFORMANT (Husband) Albert C. Winterling Address Dundalk, Md. 21222 7844 Rockbourne Rd.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic disseminated lupus erythematosus 456X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Oct. 16, 1967 , to Oct. 17, 1967 , that (I) (we) last saw the deceased alive on Oct. 17, 1967 , and that death occurred at 12:00 am , from the causes and on the date stated above.											
22a. SIGNATURE <i>John E. Adams</i> 22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D.								22b. DATE SIGNED 10/17/67 22d. ADDRESS 6701 N. Charles Street			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10/19/67 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Cem. 23d. LOCATION (City, town or county) (State) Baltimore, Md.				24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. 25a. REC'D BY REGISTRAR OCT 18 1967 25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>							

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13664

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13668

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY 853 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Welch d. STREET ADDRESS 68 Maple Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Roger WOODS		4. DATE OF DEATH Month Day Year October 20 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1941
9. AGE (In years lost birthday) 26 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY City Hall-Welch, W. Va.	
11. BIRTHPLACE (County & State, or foreign country) Marion, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leonard Wood		14. MOTHER'S MAIDEN NAME Margie Glass	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 235-62-9094	
17. INFORMANT Leonard Wood		Address Welch, West Virginia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Congestive heart failure DUE TO (b) Hypertensive cardiovascular disease DUE TO (c) Chronic glomerulonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 27 1967 , to October 20 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 20 1967 , and that death occurred at 4:20 A.M. from causes and on the date stated above.			
22a. SIGNATURE Lawrence F. Misanik		22b. DATE SIGNED 11/20/67	
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		23b. DATE THEREOF 10-22-67	
23c. NAME OF CEMETERY OR CREMATORY Yeager Memorial		23d. LOCATION (City or Town) (County) (State) Roadfield West Virginia	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212		25a. REC'D BY REGISTRAR OCT 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

VR A15 (4)
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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW/SJS/KJS
EXCEPT WHERE SHOWN OTHERWISE

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13665

13669

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home				d. STREET ADDRESS Wyman Park Apts.			
3. NAME OF DECEASED (Type or print) First Gertrude Middle C. Last Wright				4. DATE OF DEATH Month Oct. Day 8 Year 19 67			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/1886		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Feick				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-48-4500		17. INFORMANT Mrs. Frank Symington, 103 Overhill Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertensive cardiovascular disease DUE TO arteriosclerosis (c) INTERVAL BETWEEN ONSET AND DEATH one day 15-90							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 2/18, 1955 to 10/8, 1967 , that (I) (we) last saw the deceased alive on 10/7, 1967 , and that death occurred at 3P M, from causes and on the date stated above.							
22a. SIGNATURE William J. Renner				22b. DATE SIGNED 10/9/67		22c. PHYSICIAN'S NAME (Type) Dr. William Renner	
22d. ADDRESS 3222 St. Paul St.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/10/1967		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co., 4905 York Rd. Balto. 12, Md.				25a. REC'D BY REGISTRAR OCT 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1385

CENTRAL OF TEXAS

1385

THE STATE OF TEXAS, COUNTY OF DALLAS.

Know all men by these presents,

that I, J. M. [Name],

do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of Dallas, State of Texas.

Witness my hand and seal of office this 1st day of [Month], 19[Year].

J. M. [Name]

Notary Public for the State of Texas, my commission expires on the 1st day of [Month], 19[Year].

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13666

13670

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2 mths 7 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS Homeless			
3. NAME OF DECEASED (Type or print) First Middle Last Edward Young				4. DATE OF DEATH Month Day Year October 7 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?	9. AGE (In years last birthday) 60? yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10b. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (County & State, or foreign country) ?		12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Records: Spring Grove State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage, acute, site 159 X DUE TO Undetermined, characterized by massive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) rectal bleeding. Suspect carcinoma DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Azotemia, malnutrition, chronic alcoholism.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 31, 1967 , to October 7, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct 7 1967 , and that death occurred at 1:33M , from causes and on the date stated above.							
22a. SIGNATURE <i>Anthony J. Young, M.D.</i>				22b. DATE SIGNED a.m.		22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.	
22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228				22e. MED. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 13 1967		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) Old Frederick Road Balto Md	
24. FUNERAL DIRECTOR Kraus Funeral Home 1216 S Charles St #30				25a. REC'D BY REGISTRAR OCT 16 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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REMARKS ON DEATH

History

History

2 months before death

2 months before death

History

History

History

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13667

13671

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House in the Pines N.H.</u> <u>16 Fasting Ave.</u>		d. STREET ADDRESS <u>5210 Leeds Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>FRANK ZACCARI, Sr.</u>		4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/25/84</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sol Zaccari</u>		14. MOTHER'S MARDEN NAME <u>Anna Cicero</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-32-7854</u>	
17. INFORMANT <u>Anna Zaccari</u>		Address <u>5132 Westland Blvd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fibrosarcoma, right scapula with</u> <u>1964</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastasis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>67</u> , to <u>Oct. 9</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>Oct. 9</u> , 19 <u>67</u> , and that death occurred at <u>7:30 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Herbert J. Levickas</u> M.D.		22b. DATE SIGNED <u>10/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u>		22d. ADDRESS <u>5404 East Drive</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. Maryland</u>
24. FUNERAL DIRECTOR <u>Cimbur Inc. 1328 Sulphur Sp. Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 16 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF NEW YORK
IN SENATE
JANUARY 18, 1907
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1906
ALBANY: J.B. LIPPINCOTT & CO. PRINTERS
1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 11/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13665

13672

1. PLACE OF DEATH o. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MD b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER		c. LENGTH OF STAY IN 1b 6 mo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2230 HAWTHORNE RD		d. STREET ADDRESS 608 MARYLAND AVE	
3. NAME OF DECEASED (Type or print) ERNEST M. ZIMMERMAN		4. DATE OF DEATH OCT. 24 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BREW MASTER		10b. KIND OF BUSINESS OR INDUSTRY BEER	
11. BIRTHPLACE (County & State, or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK		16. SOCIAL SECURITY NO. 216-05-4081	
17. INFORMANT ERNEST J ZIMMERMAN		Address 2230 HAWTHORNE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) Cancer of Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 15 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb , 19 63 , to Oct , 19 67 , that (I) (we) lost saw the deceased alive on Oct 6 , 19 67 , and that death occurred at 8 P M, from causes on and on the date stated above.			
22a. SIGNATURE J. Lyden		22b. DATE SIGNED 10/25/67	
22c. PHYSICIAN'S NAME (Type) D. J. LYDEN		22d. ADDRESS 6402 GOLDEN RING RD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/28/67	23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH	23d. LOCATION (City or Town) (County) (State) BALTO. MD
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		25a. REC'D BY REGISTRAR OCT 27 1967	
ADDRESS 300 MACE		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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13673

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 114 Hopkins Road				d. STREET ADDRESS 114 Hopkins Road			
3. NAME OF DECEASED (Type or print) First Middle Last Catherine R. Zipprian				4. DATE OF DEATH Month Day Year October 16 19 67			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1891	9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William W. Rathbone				14. MOTHER'S MAIDEN NAME Ida Basil			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-54-0930		17. INFORMANT Alfred I. Zipprian		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) A-S Heart disease DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 2 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Disease & cerebral A.S.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/13, 1963 to 10/16, 1967 , that (I) (we) last saw the deceased alive on 10/16, 1967 , and that death occurred at 7A.M. from causes and on the date stated above.							
22a. SIGNATURE Norman R. Freeman M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/17/67	
22c. PHYSICIAN'S NAME (Type) Dr. Norman R. Freeman				22d. ADDRESS 11 W. 29th St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/1967		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.				25a. REC'D BY REGISTRAR DATE OCT 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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